

Return of Organization Exempt From Income Tax

Department of the Treasury Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

Do not enter social security numbers on this form as it may be made public.

Go to www.irs.gov/Form990 for instructions and the latest information.

A For the 2020 calendar year, or tax year beginning 07/01, 2020, and ending 06/30, 20 21

Form header section containing organization name (UNION HOSPITAL OF CECIL COUNTY, INC.), EIN (52-0607945), address (106 BOW STREET, ELKTON, MD 21921-5596), principal officer (DWIGHT THOMEY), and tax-exempt status (501(c)(3)).

Part I Summary

Summary table with columns for line number, description, Prior Year, Current Year, and Net Assets or Fund Balances. Includes rows for mission statement, governance, revenue, expenses, and net assets.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature block area with fields for officer signature, date, and name/title.

Preparer information section including name (ANTONIO C RUSSO), signature, date (05/11/2022), firm name (PRICEWATERHOUSECOOPERS LLP), and firm address.

May the IRS discuss this return with the preparer shown above? (see instructions) [X] Yes [] No

For Paperwork Reduction Act Notice, see the separate instructions.

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III [X]

1 Briefly describe the organization's mission: UNION HOSPITAL OF CECIL COUNTY, INC.'S MISSION IS TO PROVIDE CHARITABLE HEALTHCARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MARYLAND; WESTERN NEW CASTLE COUNTY, DELAWARE; AND SOUTHERN CHESTER COUNTY, PENNSYLVANIA.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? [] Yes [X] No

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? [] Yes [X] No

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses \$ 113,820,252. including grants of \$ 0.) (Revenue \$ 164,727,118.) ATTACHMENT 1

4b (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4c (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4d Other program services (Describe on Schedule O.) (Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses 113,820,252.

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A.</i>	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> See instructions?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I.</i>		X
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II.</i>		X
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? <i>If "Yes," complete Schedule C, Part III</i>		X
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I.</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II.</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		X
9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>		X
10 Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi endowments? <i>If "Yes," complete Schedule D, Part V</i>		X
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	X	
b Did the organization report an amount for investments-other securities in Part X, line 12, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>	X	
c Did the organization report an amount for investments-program related in Part X, line 13, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII.</i>		X
d Did the organization report an amount for other assets in Part X, line 15, that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX.</i>	X	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>		X
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII.</i>		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E.</i>		X
14a Did the organization maintain an office, employees, or agents outside of the United States?.		X
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>	X	
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>		X
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>		X
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I</i> See instructions		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>		X
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	X	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>		X

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question number, Description, and Yes/No response. Rows 22-38 cover various IRS schedule requirements.

Part V Statements Regarding Other IRS Filings and Tax Compliance

Check if Schedule O contains a response or note to any line in this Part V []

Table with 3 columns: Question number, Description, and Yes/No response. Rows 1a-1c cover Form 1096 and backup withholding rules.

Part V Statements Regarding Other IRS Filings and Tax Compliance (continued)

		Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return. 2a 1,525		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note: If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	X	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	X	
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O	X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .		X
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
d	If "Yes," indicate the number of Forms 8282 filed during the year 7d		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . .		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
9	Sponsoring organizations maintaining donor advised funds.		
a	Did the sponsoring organization make any taxable distributions under section 4966?		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter:		
a	Initiation fees and capital contributions included on Part VIII, line 12 10a		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities 10b		
11	Section 501(c)(12) organizations. Enter:		
a	Gross income from members or shareholders 11a		
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) 11b		
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year 12b		
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note: See the instructions for additional information the organization must report on Schedule O.		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans 13b		
c	Enter the amount of reserves on hand 13c		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		X
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on Schedule O		
15	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N.		X
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.		X

Part VI Governance, Management, and Disclosure For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes on Schedule O. See instructions.

Check if Schedule O contains a response or note to any line in this Part VI [X]

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (13), 1b (10), 2 (X), 3 (X), 4 (X), 5 (X), 6 (X), 7a (X), 7b (X), 8a (X), 8b (X), 9 (X).

Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)

Table with 3 columns: Question, Yes, No. Rows include: 10a (X), 10b, 11a (X), 11b, 12a (X), 12b (X), 12c (X), 13 (X), 14 (X), 15a (X), 15b (X), 16a (X), 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed MD,
18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (Section 501(c) (3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
19 Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII X

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
 - List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
 - List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
 - List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.
- See instructions for the order in which to list the persons above.

Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) KENNETH SILVERSTEIN, MD DIRECTOR (AS OF 01/01/21)	1.00 44.00	X					0.	903,548.	108,459.	
(2) JUSTIN SAUSVILLE, MD DIRECTOR, PHYSICIAN	44.00 1.00	X					669,752.	0.	31,686.	
(3) JENNIFER L. SCHWARTZ, ESQ. SECRTY, EX OFF. (AS OF 01//21)	1.00 44.00	X		X			0.	590,868.	82,750.	
(4) ROGER D. WU, MD PHYSICIAN	45.00 0.					X	616,107.	0.	27,392.	
(5) RICHARD C. SZUMEL, MD PRESIDENT & CEO (THRU 12/20)	32.00 13.00	X		X			0.	579,208.	51,972.	
(6) FAHD RAHMAN, MD PHYSICIAN	45.00 0.					X	586,541.	0.	31,555.	
(7) NAVEED HASAN, MD PHYSICIAN	45.00 0.					X	544,453.	0.	15,158.	
(8) RYAN T. GERACIMOS, MD CHIEF MEDICAL OFFICER	43.00 2.00					X	0.	461,364.	6,369.	
(9) EUGENIA M. GRAY, MD PHYSICIAN	45.00 0.					X	410,533.	0.	19,763.	
(10) JOHN M. HEBEKA, MD PHYSICIAN	45.00 0.					X	422,811.	0.	7,034.	
(11) JAMES G. RAAB SENIOR VP/CFO (THRU 10/09/20)	41.00 4.00			X			0.	328,136.	21,286.	
(12) JOSE MA, MD DIRECTOR	44.00 1.00	X					279,933.	0.	29,898.	
(13) MICHELLE TWUM-DANSO DIRECTOR HR SERVICES	45.00 0.					X	220,701.	0.	3,780.	
(14) JOAN PIRRUNG VP OF NURSING	44.00 1.00					X	0.	168,031.	53,264.	

Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(15) AMY MARSTON ----- CAMPUS OPERATIONS OFFICER	44.00 ----- 1.00				X			0.	193,437.	26,740.
(16) DERON BROWN ----- EXEC DIRECTOR OF FINANCE	44.00 ----- 1.00				X			178,336.	0.	2,372.
(17) CRAIG M. BABBITT, ESQ. ----- FMR IN-HOUSE LEGAL COUNSEL	0. ----- 0.						X	176,256.	0.	0.
(18) BETTY CAFFO ----- DIRECTOR (AS OF 01/01/21)	1.00 ----- 3.00	X						0.	0.	0.
(19) CARL ROBERTS, PH.D. ----- DIRECTOR	1.00 ----- 1.00	X						0.	0.	0.
(20) CHRISTY DRYER, DNP ----- DIRECTOR	1.00 ----- 1.00	X						0.	0.	0.
(21) DAVID TROLIO ----- DIRECTOR	1.00 ----- 1.00	X						0.	0.	0.
(22) DWIGHT THOMEY ----- CHAIRMAN (AS OF 01/01/21)	1.00 ----- 3.00	X		X				0.	0.	0.
(23) JACQUES RENE ----- DIRECTOR	1.00 ----- 1.00	X						0.	0.	0.
(24) LEO NAJERA ----- DIRECTOR (AS OF 01/01/21)	1.00 ----- 2.00	X						0.	0.	0.
(25) MORGAN MILLER, MLIS ----- VICE CHAIRMAN (AS OF 01/01/21)	1.00 ----- 1.00	X		X				0.	0.	0.
1b Sub-total								4,105,423.	3,224,592.	519,478.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								4,105,423.	3,224,592.	519,478.

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ► 10

	Yes	No
3 Did the organization list any former officer, director, or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	X	
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i>	X	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i>		X

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
ATTACHMENT 2		

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization ► 67

Part VIII Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a					
	b	Membership dues	1b					
	c	Fundraising events	1c					
	d	Related organizations	1d	188,891.				
	e	Government grants (contributions) . .	1e	3,932,250.				
	f	All other contributions, gifts, grants, and similar amounts not included above .	1f	32,700.				
	g	Noncash contributions included in lines 1a-1f.	1g	\$				
	h	Total. Add lines 1a-1f ▶		4,153,841.				
	Program Service Revenue				Business Code			
2a		NET PATIENT SERVICE REVENUE		621990	164,047,954.	164,047,954.		
b		OTHER OPERATING REVENUE		621990	612,964.	611,449.	1,515.	
c		ADULT DAY CARE		623990	66,200.	30,200.	36,000.	
d								
e								
f		All other program service revenue						
g		Total. Add lines 2a-2f ▶			164,727,118.			
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts). ▶			689,493.		135,949.	
	4	Income from investment of tax-exempt bond proceeds . ▶			0.			
	5	Royalties ▶			0.			
	6a	Gross rents	6a	(i) Real				
				(ii) Personal				
					70,611.			
	b	Less: rental expenses	6b		7,954.			
	c	Rental income or (loss)	6c		62,657.			
	d	Net rental income or (loss) ▶			62,657.		62,657.	
	7a	Gross amount from sales of assets other than inventory	7a	(i) Securities				
				(ii) Other				
					39,298,046.	1,517,297.		
	b	Less: cost or other basis and sales expenses . .	7b		34,290,366.	1,203,877.		
	c	Gain or (loss)	7c		5,007,680.	313,420.		
	d	Net gain or (loss) ▶			5,321,100.		76,194.	
8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	8a		0.				
b	Less: direct expenses	8b		0.				
c	Net income or (loss) from fundraising events. ▶			0.				
9a	Gross income from gaming activities. See Part IV, line 19	9a		0.				
b	Less: direct expenses	9b		0.				
c	Net income or (loss) from gaming activities. ▶			0.				
10a	Gross sales of inventory, less returns and allowances	10a			0.			
					0.			
					0.			
c	Net income or (loss) from sales of inventory. ▶			0.				
Miscellaneous Revenue				Business Code				
	11a	LABORATORY REVENUE		621500	2,587,855.	2,587,855.		
	b	CAFETERIA/FOOD SERVICE REVENUE		722210	368,339.		368,339.	
	c	PARKING REVENUE		900009	20,772.		20,772.	
	d	All other revenue			75,562.		75,562.	
e	Total. Add lines 11a-11d ▶			3,052,528.				
12	Total revenue. See instructions ▶			178,006,737.	164,689,603.	2,837,513.	6,325,780.	

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX [X]

Table with 5 columns: (A) Total expenses, (B) Program service expenses, (C) Management and general expenses, (D) Fundraising expenses. Rows include categories like Grants, Salaries, Pension, Advertising, etc.

Part X Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	37,308,503.	1	43,902,759.
	2 Savings and temporary cash investments	0.	2	0.
	3 Pledges and grants receivable, net	0.	3	0.
	4 Accounts receivable, net.	14,177,794.	4	12,390,270.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0.	5	0.
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B).	0.	6	0.
	7 Notes and loans receivable, net	0.	7	0.
	8 Inventories for sale or use	2,523,066.	8	2,985,406.
	9 Prepaid expenses and deferred charges	3,244,897.	9	3,831,631.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 184,372,595.		
	b Less: accumulated depreciation	10b 132,386,063.	50,230,601.	10c 51,986,532.
	11 Investments - publicly traded securities.	ATCH 4	30,670,970.	11 43,359,783.
	12 Investments - other securities. See Part IV, line 11		13,031,319.	12 11,546,080.
	13 Investments - program-related. See Part IV, line 11.		0.	13 0.
	14 Intangible assets		0.	14 0.
	15 Other assets. See Part IV, line 11		9,466,519.	15 14,993,547.
16 Total assets. Add lines 1 through 15 (must equal line 33)		160,653,669.	16 184,996,008.	
Liabilities	17 Accounts payable and accrued expenses		17	27,438,025.
	18 Grants payable		18	0.
	19 Deferred revenue.		19	24,763,483.
	20 Tax-exempt bond liabilities.		20	51,404,224.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D.		21	0.
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		22	0.
	23 Secured mortgages and notes payable to unrelated third parties		23	0.
	24 Unsecured notes and loans payable to unrelated third parties.		24	0.
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		25	15,269,269.
	26 Total liabilities. Add lines 17 through 25.		108,476,881.	26 118,875,001.
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions		27	62,735,295.
	28 Net assets with donor restrictions.		28	3,385,712.
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund.		30	
	31 Retained earnings, endowment, accumulated income, or other funds.		31	
	32 Total net assets or fund balances		32	66,121,007.
33 Total liabilities and net assets/fund balances.		33	184,996,008.	

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI

1	Total revenue (must equal Part VIII, column (A), line 12)	1	178,006,737.
2	Total expenses (must equal Part IX, column (A), line 25)	2	169,940,414.
3	Revenue less expenses. Subtract line 2 from line 1	3	8,066,323.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	52,176,788.
5	Net unrealized gains (losses) on investments	5	4,641,378.
6	Donated services and use of facilities	6	0.
7	Investment expenses	7	0.
8	Prior period adjustments	8	0.
9	Other changes in net assets or fund balances (explain on Schedule O)	9	1,236,518.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	66,121,007.

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII.

- 1** Accounting method used to prepare the Form 990: Cash Accrual Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits

	Yes	No
2a		X
2b	X	
2c	X	
3a		X
3b		

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

2020

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Part I Reason for Public Charity Status. (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2 A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E (Form 990 or 990-EZ).)
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8 A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9 An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____
- 10 An organization that normally receives (1) more than 33 1/3 % of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions, subject to certain exceptions; and (2) no more than 33 1/3 % of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)
- 11 An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 12 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3)**.
Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.

f Enter the number of supported organizations

g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
(A)						
(B)						
(C)						
(D)						
(E)						
Total						

Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Table with 7 columns: (a) 2016, (b) 2017, (c) 2018, (d) 2019, (e) 2020, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Tax revenues levied for the organization's benefit; 3 The value of services or facilities furnished by a governmental unit; 4 Total. Add lines 1 through 3; 5 The portion of total contributions by each person; 6 Public support. Subtract line 5 from line 4.

Section B. Total Support

Table with 7 columns: (a) 2016, (b) 2017, (c) 2018, (d) 2019, (e) 2020, (f) Total. Rows include: 7 Amounts from line 4; 8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 9 Net income from unrelated business activities; 10 Other income. Do not include gain or loss from the sale of capital assets; 11 Total support. Add lines 7 through 10; 12 Gross receipts from related activities, etc. (see instructions); 13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.

Section C. Computation of Public Support Percentage

Table with 2 columns: Percentage, %. Rows include: 14 Public support percentage for 2020; 15 Public support percentage from 2019 Schedule A, Part II, line 14; 16a 33 1/3% support test - 2020; b 33 1/3% support test - 2019; 17a 10%-facts-and-circumstances test - 2020; b 10%-facts-and-circumstances test - 2019; 18 Private foundation.

Part III Support Schedule for Organizations Described in Section 509(a)(2)
 (Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II.
 If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5.						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
9 Amounts from line 6.						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

14 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**

Section C. Computation of Public Support Percentage

15 Public support percentage for 2020 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2019 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2020 (line 10c, column (f), divided by line 13, column (f)).	17	%
18 Investment income percentage from 2019 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2020. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization . ►

b 33 1/3% support tests - 2019. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ►

Part IV Supporting Organizations

(Complete only if you checked a box in line 12 on Part I. If you checked box 12a, Part I, complete Sections A and B. If you checked box 12b, Part I, complete Sections A and C. If you checked box 12c, Part I, complete Sections A, D, and E. If you checked box 12d, Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer lines 3b and 3c below.</i>		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.</i>		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in Part VI, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in Part VI.</i>		
b Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in Part VI.</i>		
c Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in Part VI.</i>		
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		

Part IV Supporting Organizations (continued)

	Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described in lines 11b and 11c below, the governing body of a supported organization?		
b A family member of a person described in line 11a above?		
c A 35% controlled entity of a person described in line 11a or 11b above? <i>If "Yes" to line 11a, 11b, or 11c, provide detail in Part VI.</i>		

Section B. Type I Supporting Organizations

	Yes	No
1 Did the governing body, members of the governing body, officers acting in their official capacity, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's officers, directors, or trustees at all times during the tax year? <i>If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove officers, directors, or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.</i>		
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <i>If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.</i>		

Section C. Type II Supporting Organizations

	Yes	No
1 Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? <i>If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).</i>		

Section D. All Type III Supporting Organizations

	Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
3 By reason of the relationship described in line 2, above, did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		

Section E. Type III Functionally Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).			
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a governmental entity (see instructions).			
2 Activities Test. Answer lines 2a and 2b below.		Yes	No
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>			
b Did the activities described in line 2a, above, constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>			
3 Parent of Supported Organizations. Answer lines 3a and 3b below.			
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>If "Yes" or "No," provide details in Part VI.</i>			
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>			

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations

1 Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (*explain in Part VI*). See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3.	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6, and 7 from line 4)	8	

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (<i>explain in detail in Part VI</i>):	1e	
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d.	3	
4	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by 0.035.	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, column A)	1	
2	Enter 0.85 of line 1.	2	
3	Minimum asset amount for prior year (from Section B, line 8, column A)	3	
4	Enter greater of line 2 or line 3.	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations (continued)

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i>)	5
6	Other distributions (<i>describe in Part VI</i>). See instructions.	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (<i>provide details in Part VI</i>). See instructions.	8
9	Distributable amount for 2020 from Section C, line 6	9
10	Line 8 amount divided by line 9 amount	10

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2020	(iii) Distributable Amount for 2020
1	Distributable amount for 2020 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2020 (reasonable cause required - <i>explain in Part VI</i>). See instructions.			
3	Excess distributions carryover, if any, to 2020			
a	From 2015			
b	From 2016			
c	From 2017			
d	From 2018			
e	From 2019			
f	Total of lines 3a through 3e			
g	Applied to underdistributions of prior years			
h	Applied to 2020 distributable amount			
i	Carryover from 2015 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4	Distributions for 2020 from Section D, line 7: \$			
a	Applied to underdistributions of prior years			
b	Applied to 2020 distributable amount			
c	Remainder. Subtract lines 4a and 4b from line 4.			
5	Remaining underdistributions for years prior to 2020, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
6	Remaining underdistributions for 2020. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
7	Excess distributions carryover to 2021. Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2016			
b	Excess from 2017			
c	Excess from 2018			
d	Excess from 2019			
e	Excess from 2020			

Part VI **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions.)

Schedule of Contributors

2020

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
 ▶ Go to www.irs.gov/Form990 for the latest information.

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
--	--

Organization type (check one):

Filers of:

Section:

- Form 990 or 990-EZ 501(c)(3) (enter number) organization
- 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
- 527 political organization
- Form 990-PF 501(c)(3) exempt private foundation
- 4947(a)(1) nonexempt charitable trust treated as a private foundation
- 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

- For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

- For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** \$5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.
- For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization **UNION HOSPITAL OF CECIL COUNTY, INC.**

Employer identification number
52-0607945

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	MARYLAND HOSPITAL ASSOCIATION 6820 DEERPATH ROAD ELKRIDGE, MD 21075	\$ 25,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	SISCO - RCM&D SELF INSURED SRVS CO, INC. 555 FAIRMOUNT AVE BALTIMORE, MD 21286	\$ 7,700.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3	UNION HOSP. OF CECIL COUNTY FDN., INC. 106 BOW STREET ELKTON, MD 21921	\$ 188,891.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
_____	_____ _____ _____	\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization **UNION HOSPITAL OF CECIL COUNTY, INC.**

Employer identification number

52-0607945

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____
_____	_____ _____ _____	\$ _____	_____

Name of organization **UNION HOSPITAL OF CECIL COUNTY, INC.**

Employer identification number
52-0607945

Part III *Exclusively* religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of **\$1,000 or less** for the year. (Enter this information once. See instructions.) ► \$ _____
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
_____ _____ _____	_____ _____ _____

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
_____ _____ _____	_____ _____ _____

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
_____ _____ _____	_____ _____ _____

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
_____ _____ _____	_____ _____ _____

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

2020

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Complete if the organization answered "Yes" on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.

Attach to Form 990.

Go to www.irs.gov/Form990 for instructions and the latest information.

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include total number at end of year, aggregate value of contributions, grants, and end of year, and two questions about donor advisement with Yes/No checkboxes.

Part II Conservation Easements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

Table with 2 columns: Description, Held at the End of the Tax Year. Rows include purpose(s) of conservation easements, total number of easements, acreage, and number of easements on historic structures, and questions about monitoring and expenses.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

Table with 2 columns: Description, Amount. Rows include questions about reporting art and historical treasures, and amounts for revenue and assets.

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule D (Form 990) 2020

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

- 3** Using the organization's acquisition, accession, and other records, check any of the following that make significant use of its collection items (check all that apply):
- a** Public exhibition
 - b** Scholarly research
 - c** Preservation for future generations
 - d** Loan or exchange program
 - e** Other _____
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5** During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? **Yes** **No**

Part IV Escrow and Custodial Arrangements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? **Yes** **No**
- b** If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|--|-----------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? **Yes** **No**
- b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

Part V Endowment Funds.

Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

- a** Board designated or quasi-endowment ▶ _____ %
- b** Permanent endowment ▶ _____ %
- c** Term endowment ▶ _____ %

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

- (i)** Unrelated organizations
- (ii)** Related organizations

	Yes	No
3a(i)		
3a(ii)		
3b		

b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,134,905.		1,134,905.
b Buildings		47,106,818.	28,587,192.	18,519,626.
c Leasehold improvements		961,333.	400,751.	560,582.
d Equipment		126,906,579.	99,070,537.	27,836,042.
e Other		8,262,960.	4,327,583.	3,935,377.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				51,986,532.

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely held equity interests	6,261,585.	ATTACHMENT 1
(3) Other		
(A) MANAGED HEDGE FUNDS	5,284,495.	FMV
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) . ▶	11,546,080.	

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 13.) . ▶		

Part IX Other Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) OTHER ASSETS	726,189.
(2) INSURANCE CLAIMS RECOVERABLE	7,699,683.
(3) DUE FROM AFFILIATES	659,189.
(4) ROU LEASES	5,908,486.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	14,993,547.

Part X Other Liabilities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) CAPITAL LEASE OBLIGATIONS	1,238,951.
(3) EST. MEDICAL MALPRACTICE LIABILITY	8,895,187.
(4) ROU LEASES	3,672,472.
(5) DEFERRED FICA	1,360,275.
(6) CYBER LIABILITY	102,384.
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	15,269,269.

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FASB ASC 740. Check here if the text of the footnote has been provided in Part XIII .

Part XIII Supplemental Information (continued)

ATTACHMENT 1

SCHEDULE D, PART VII - INVESTMENTS - CLOSELY HELD EQUITY INTERESTS

DESCRIPTION	BOOK VALUE	COST OR FMV
CLOSELY-HELD EQUITY INTERESTS	6,261,585.	COST
TOTALS	6,261,585.	

**SCHEDULE F
(Form 990)**

Statement of Activities Outside the United States

OMB No. 1545-0047

2020

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 14b, 15, or 16.**
▶ **Attach to Form 990.**
▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Part I General Information on Activities Outside the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

- 1 **For grantmakers.** Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? **Yes** **No**
- 2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.

3 **Activities per Region.** (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in the region	(d) Activities conducted in the region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in the region	(f) Total expenditures for and investments in the region
(1) CENTRAL AMERICA/CARIBBEAN	0.	0.	INVESTMENTS		20,000.
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
3a Subtotal					20,000.
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)					20,000.

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule F (Form 990) 2020

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than \$5,000. Part II can be duplicated if additional space is needed.

1	(a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of noncash assistance	(h) Description of noncash assistance	(i) Method of valuation (book, FMV, appraisal, other)
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
(11)									
(12)									
(13)									
(14)									
(15)									
(16)									

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as a tax exempt 501(c)(3) organization by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter . . . ▶ _____

3 Enter total number of other organizations or entities ▶ _____

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16.
 Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of noncash assistance	(g) Description of noncash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							

Part IV Foreign Forms

- 1 Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)* Yes No
- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return To Report Transactions With Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; don't file with Form 990)* Yes No
- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect to Certain Foreign Corporations (see Instructions for Form 5471)* Yes No
- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)* Yes No
- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect to Certain Foreign Partnerships (see Instructions for Form 8865)* Yes No
- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713; don't file with Form 990)* Yes No

Part V **Supplemental Information**

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information (see instructions).

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2020

Open to Public Inspection

▶ Complete if the organization answered "Yes" on Form 990, Part IV, question 20.

▶ Attach to Form 990.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

Department of the Treasury
Internal Revenue Service

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	X	
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	X	

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			1,763,800.		1,763,800.	1.04
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			1,763,800.		1,763,800.	1.04
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)		21853	1,541,061.		1,541,061.	.91
f Health professions education (from Worksheet 5)		158	140,793.		140,793.	.08
g Subsidized health services (from Worksheet 6)			19,707,732.	9,037,022.	10,670,710.	6.28
h Research (from Worksheet 7)			14,531.		14,531.	.01
i Cash and in-kind contributions for community benefit (from Worksheet 8)		351	140,049.		140,049.	.08
j Total. Other Benefits		22362	21,544,166.	9,037,022.	12,507,144.	7.36
k Total. Add lines 7d and 7j		22362	23,307,966.	9,037,022.	14,270,944.	8.40

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule H (Form 990) 2020

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development			1,936.		1,936.	
3 Community support			387.		387.	
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			2,323.		2,323.	

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	X	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	78,200,560.
6 Enter Medicare allowable costs of care relating to payments on line 5	78,200,560.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	
8 Describe in Part VI the extent to which any shortfall reported on line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other	

Section C. Collection Practices

9a Did the organization have a written debt collection policy during the tax year?	X	
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI	X	

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, from largest to smallest - see instructions)

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

1 UNION HOSPITAL OF CECIL COUNTY, INC.
 106 BOW STREET
 ELKTON MD 21921
 WWW.UHCC.COM
 LICENSE# 07-005

Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
X	X					X			

Part V Facility Information (continued)

Section B. Facility Policies and Practices

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group UNION HOSPITAL OF CECIL COUNTY, INC.

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

		Yes	No
Community Health Needs Assessment			
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply):	X	
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>19</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	X	
6b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	X	
7	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	X	
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V, SECTION C</u>		
b	<input checked="" type="checkbox"/> Other website (list url): <u>SEE PART V, SECTION C</u>		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a	If "Yes," (list url): <u>SEE PART V, SECTION C</u>		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group UNION HOSPITAL OF CECIL COUNTY, INC.

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>400.0000</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input checked="" type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	X	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j	<input checked="" type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group UNION HOSPITAL OF CECIL COUNTY, INC.

		Yes	No
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged:		X
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a	<input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
b	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
c	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
d	<input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	X	
If "No," indicate why:			
a	<input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b	<input type="checkbox"/> The hospital facility's policy was not in writing		
c	<input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d	<input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information *(continued)*

Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)

Name of hospital facility or letter of facility reporting group UNION HOSPITAL OF CECIL COUNTY, INC.

		Yes	No
22	Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.		
a	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d	<input checked="" type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Section C.		X
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Section C.		X

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

PART V, SECTION B, LINES 5, 6A & 6B (INPUT FROM COMMUNITY; JOINT CHNA)

TO CREATE THE 2019 CHNA AND COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP), UNION HOSPITAL CONTINUED TO WORK IN PARTNERSHIP WITH THE CECIL COUNTY HEALTH DEPARTMENT (CCHD). TO LEARN DIRECTLY FROM THE COMMUNITY, UNION HOSPITAL AND CCHD (THE PLANNING TEAM) DEVELOPED A SURVEY, HELD FOCUS GROUPS, AND CONDUCTED INTERVIEWS WITH LOCAL LEADERS.

THE SURVEY CONSISTED OF 20 QUESTIONS DIVIDED INTO 4 SECTIONS PERTAINING TO DEMOGRAPHICS, COMMUNITY HEALTH, QUALITY OF LIFE, AND ACCESS TO HEALTH CARE. 1,403 INDIVIDUALS COMPLETED THE SURVEY WHICH WAS AVAILABLE FROM JULY 2018 TO SEPTEMBER 2018 ONLINE AND IN PAPER FORM AT COMMUNITY LOCATIONS SUCH AS THE COUNTY PUBLIC LIBRARIES AND UNION HOSPITAL'S MULTI-SPECIALTY PRACTICES.

THE PLANNING TEAM ALSO HOSTED FOUR FOCUS GROUPS FOR VULNERABLE POPULATIONS: HOMELESS, VETERANS, OLDER ADULTS, AND LOW-INCOME OR ASSET LIMITED INCOME CONSTRAINED EMPLOYED (ALICE) ADULTS. A FIFTH FOCUS GROUP WITH AFRICAN AMERICANS WAS ALSO HELD TO DISCUSS HEALTH DISPARITIES IN CECIL COUNTY.

EACH FOCUS GROUP SESSION LASTED ONE TO ONE AND A HALF HOURS AND ALWAYS BEGAN WITH A DESCRIPTION OF THE CHNA, THE PURPOSE OF THE FOCUS GROUP, THE RULES OF ENGAGEMENT, AND A REFERENCE WORKSHEET WITH SESSION QUESTIONS. PARTICIPATION WAS ANONYMOUS WITH A HEAD COUNT PROVIDING THE NUMBER OF

Part V Facility Information *(continued)*

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

PARTICIPANTS. THE AVERAGE FOR EACH SESSION WAS TEN PARTICIPANTS. AT EACH SESSION, THE FOLLOWING QUESTIONS WERE ASKED:

- 1) WHAT ARE THE GREATEST STRENGTHS OF OUR COMMUNITY?
- 2) WHAT DO YOU THINK ARE THE MOST IMPORTANT HEALTH ISSUES IN CECIL COUNTY?
- 3) WHAT WOULD MOST IMPROVE THE QUALITY OF LIFE IN CECIL COUNTY?
- 4) WHAT ARE THE MOST SIGNIFICANT BARRIERS TO ACCESSING HEALTH CARE IN CECIL COUNTY?
- 5) RELATED TO HEALTH AND QUALITY OF LIFE, WHAT RESOURCES OR SERVICES DO YOU THINK ARE MISSING IN CECIL COUNTY?

FINALLY, INTERVIEWS WITH LOCAL LEADERS WERE CONDUCTED TO UNDERSTAND WHAT THEY PERCEIVE AS THE GREATEST CHALLENGES FOR CECIL COUNTY RESIDENTS. TWELVE INTERVIEWS WITH TWO TO FIVE COMMUNITY LEADERS WERE CONDUCTED BY UNION HOSPITAL. TO ENSURE PARTICIPANTS FELT FREE TO SHARE THEIR THOUGHTS, PARTICIPATION WAS KEPT CONFIDENTIAL.

SCHEDULE H, PART V, SECTION B, LINE 7A & B (CHNA AVAILABILITY)

UNION HOSPITAL OF CECIL COUNTY, INC.'S CHNA IS AVAILABLE ON ITS WEBSITE AT: [HTTPS://WWW.UHCC.COM/ABOUT-US/COMMUNITY-BENEFIT/REPORTS/](https://www.uhcc.com/about-us/community-benefit/reports/)

UNION HOSPITAL OF CECIL COUNTY, INC.'S CHNA IS ALSO AVAILABLE AT:

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

[HTTPS://CECILCOUNTYHEALTH.ORG/RESOURCES/HEALTH-ADVISORY-COMMITTEE/](https://cecilcountyhealth.org/resources/health-advisory-committee/)

SCHEDULE H, PART V, SECTION B, LINE 10 (IMP. STRATEGY PUBLIC AVAILABILITY)

UNION HOSPITAL OF CECIL COUNTY, INC.'S CHIP IS AVAILABLE ON ITS WEBSITE AT: [HTTP://WWW.UHCC.COM/ABOUT-US/COMMUNITY-BENEFIT/REPORTS/](http://www.uhcc.com/about-us/community-benefit/reports/)

SCHEDULE H, PART V, SECTION B, LINE 11 (ADDRESSING NEEDS FROM THE CHNA)

UNION HOSPITAL'S MOST RECENT CHNA PRIORITIZED THE FOLLOWING HEALTH NEEDS IN COLLABORATION WITH THE CECIL COUNTY HEALTH DEPARTMENT (CCHD) AND THE CECIL COUNTY COMMUNITY HEALTH ADVISORY COMMITTEE (CHAC):

- CANCER
- BEHAVIORAL HEALTH (COMPRISED OF MENTAL HEALTH AND SUBSTANCE USE)
- CHILDHOOD TRAUMA

CANCER INCIDENCE RATES HAVE STEADILY DECLINED IN CECIL COUNTY OVER THE LAST SEVERAL YEARS, BUT THE INCIDENCE RATE REMAINS HIGH IN COMPARISON TO THE STATE AND NATION. UNFORTUNATELY, CANCER HAS HAD AN IMPACT ON MANY CECIL COUNTY RESIDENTS.

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

FOR THE LAST TEN YEARS, BEHAVIORAL HEALTH HAS BEEN PRIORITIZED AS AN AREA OF NEED. IN THE 2013 AND 2016 CHNAS, SUBSTANCE USE WAS IDENTIFIED AS THE NUMBER ONE HEALTH PRIORITY FOLLOWED BY MENTAL HEALTH. ILLICIT DRUG USE HAS BEEN INCREASING IN CECIL COUNTY IN RECENT YEARS, WITH OPIOID USE AND OVERDOSES HAVING A SIGNIFICANT IMPACT IN OUR COMMUNITY.

FINALLY, CHILDHOOD TRAUMA WAS IDENTIFIED AS AN AREA OF NEED BECAUSE OF THE LIKELIHOOD THAT MEMBERS IN OUR COMMUNITY SUFFERED A TRAUMA IN CHILDHOOD AND THE DAMAGING IMPACT IT HAS THROUGHOUT LIFE. ADVERSE CHILDHOOD EXPERIENCES (ACE) IS THE TERM COMMONLY USED TO DESCRIBE ALL TYPES OF ABUSE, NEGLECT, AND OTHER POTENTIALLY TRAUMATIC EXPERIENCES THAT OCCUR TO PEOPLE UNDER THE AGE OF 18. ACES HAVE BEEN LINKED TO RISKY BEHAVIORS, CHRONIC HEALTH CONDITIONS, LOW LIFE POTENTIAL AND PREMATURE DEATH. NEARLY TWO-THIRDS OF ADULTS IN CECIL COUNTY REPORTED EXPERIENCING AT LEAST ONE ACE DURING THEIR CHILDHOOD (2019 CHNA, PAGE 26).

CHRISTIANACARE IS CURRENTLY DEVELOPING UNION HOSPITAL'S 2022 CHNA IN COLLABORATION WITH THE CCHD. THE 2022 CHNA IS THE FIRST CHRISTIANACARE HAS UNDERTAKEN IN CECIL COUNTY, AND WE ARE PLEASED THAT THE CCHD WILL CONTINUE TO WORK WITH US TO COMPLETE THE ASSESSMENT. CHRISTIANACARE OFFICE OF HEALTH EQUITY, WHICH IS RESPONSIBLE FOR COMPLETING THE CHNAS AND CHIPS FOR CHRISTIANACARE HOSPITALS, WILL BE MAKING A SIGNIFICANT ADJUSTMENT FROM UNION HOSPITAL'S PRIOR CHNAS AND CHIPS. BEGINNING WITH THE 2022 CHNA, UNION HOSPITAL WILL PRIORITIZE AREAS OF NEED BASED ON COMMUNITY INPUT AND SECONDARY DATA AS WELL AS UNION HOSPITAL'S ABILITY TO

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

ADDRESS THESE NEEDS INDEPENDENTLY OF THE CHAC OR CCHD. FURTHER, THE 2022 CHIP WILL INCLUDE SPECIFIC UNION HOSPITAL ACTIVITIES TO ADDRESS THE AREAS OF NEED. THE 2019 CHIP INCLUDED WORK PLANS IN EACH OF THE THREE AREAS OF NEED: CANCER, BEHAVIORAL HEALTH, AND CHILDHOOD TRAUMA THAT WERE DESIGNED TO BE LED BY THE CHAC WITHOUT DETAIL OF HOW UNION HOSPITAL WOULD ADDRESS THESE AREAS OF NEED EITHER IN PARTNERSHIP OR INDEPENDENTLY. AT CHRISTIANACARE, WE FIRMLY BELIEVE THAT WE CAN BEST SERVE OUR COMMUNITY THROUGH PARTNERSHIPS. THIS ADJUSTMENT IS NOT BEING DONE BECAUSE WE BELIEVE WE CAN EFFECT CHANGE WITHOUT OUR COMMUNITY PARTNERS, BUT RATHER, BECAUSE WE WANT TO SHARE WITH OUR COMMUNITY OUR SPECIFIC INTENTIONS TO ADDRESS THE PRIORITIZED AREAS OF NEED.

CANCER

UNION HOSPITAL'S COMPREHENSIVE CANCER SERVICES INCLUDE PREVENTION, DETECTION, INPATIENT AND OUTPATIENT TREATMENT, FOLLOW-UP CARE, AND ONGOING SUPPORT THROUGH A DEDICATED ONCOLOGY SOCIAL WORKER AND THE OPPORTUNITY TO PARTICIPATE IN SUPPORT GROUPS SUCH AS THE BREAST CANCER SUPPORT GROUP. THE UNION HOSPITAL CANCER PROGRAM IS CERTIFIED BY THE COMMISSION ON CANCER OF THE AMERICAN COLLEGE OF SURGEONS AND IS A RECIPIENT OF ITS PRESTIGIOUS OUTSTANDING ACHIEVEMENT AWARD. INPATIENT AND OUTPATIENT SERVICES ARE OFFERED AT UNION HOSPITAL, AT CHRISTIANACARE'S HELEN F. GRAHAM CANCER CENTER & RESEARCH INSTITUTE, AND RADIATION ONCOLOGISTS, PA.

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

IN FISCAL YEAR 2021, UNION HOSPITAL CONTINUED TO PROVIDE SCREENINGS FOR LUNG, BREAST, COLORECTAL, AND PROSTATE CANCERS WHICH ARE CANCERS THAT WERE THE FOCUS OF OUR 2019 CHNA, AND TO PROVIDE INFORMATION TO ELIGIBLE PATIENTS FOR SCREENINGS PROVIDED BY THE CECIL COUNTY HEALTH DEPARTMENT. FOR THE PAST SEVERAL YEARS, FREE SCREENINGS FOR HEAD AND NECK CANCERS AND PROSTATE SCREENINGS HAVE BEEN OFFERED. UNFORTUNATELY, DUE TO THE CORONAVIRUS PANDEMIC, THESE SCREENINGS WERE NOT HELD. THERE WAS A BRIGHT SPOT LAST YEAR THOUGH, WHICH WAS A COLLABORATIVE EVENT WITH CECIL COUNTY PUBLIC SCHOOLS AND THE UNION HOSPITAL BREAST CENTER IN AUGUST 2020. FORTY-ONE CECIL COUNTY EDUCATORS RECEIVED A MAMMOGRAM AT UNION HOSPITAL AND DUE TO THAT SUCCESS, WE PLANNED AN EVENT FOR FISCAL YEAR 2022.

UNION HOSPITAL CONTINUES TO PROVIDE LOW-DOSE CT (LDCT) SCREENINGS FOR LUNG CANCER WHICH DETECT MALIGNANT TUMORS BEFORE SYMPTOMS APPEAR. THIS SCREENING IS SIGNIFICANT BECAUSE THE EARLIER LUNG CANCER CAN BE DETECTED, THE BETTER THE CHANCE OF SURVIVAL. LDCT SCANS ARE RECOMMENDED FOR THOSE:

- BETWEEN THE AGES OF 55 AND 74 YEARS OLD
- CURRENT SMOKER OR HAVE QUIT IN THE PAST 15 YEARS
- HAVE NO SYMPTOMS OF LUNG CANCER
- HAVE A 30 PACK YEAR SMOKING HISTORY (PACK YEAR = NUMBER OF PACKS OF CIGARETTES SMOKED PER DAY MULTIPLIED BY NUMBER OF YEARS AS A SMOKER)

IN FISCAL YEAR 2021, 298 PATIENTS RECEIVED THE LDCT SCAN AT UNION HOSPITAL. WE HAD EXPECTED FEWER LDCT SCANS DUE TO THE PANDEMIC, BUT THIS

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

IS SIGNIFICANTLY HIGHER THAN THE 241 SCANS COMPLETED IN FISCAL YEAR 2020.

BECAUSE SMOKING IN ADULTS IN CECIL COUNTY DOUBLED FROM 2014 TO 2017 (2019

CHNA, PAGE 14) THIS PARTICULAR SCREENING IS A CRITICALLY IMPORTANT

OFFERING FOR THE COMMUNITY.

DUE TO THE INCREASE IN SMOKING IN CECIL COUNTY, AND COMMUNITY CONCERN

WITH RESPIRATORY DISEASES INCLUDING LUNG CANCER, UNION HOSPITAL ALSO

IMPLEMENTED THE ABILITY TO REFER PATIENTS THROUGH THEIR ELECTRONIC HEALTH

RECORD TO CECIL COUNTY HEALTH DEPARTMENT TOBACCO CESSATION PROGRAMS.

ANOTHER IMPORTANT ASPECT OF THE 2020 - 2022 CHIP IS TO SUPPORT THE WORK

OF CECIL COUNTY CANCER TASK FORCE, WHICH IS COMPRISED OF LEADERS IN

CANCER CARE, COMMUNITY HEALTH, SOCIAL SUPPORTS, PUBLIC HEALTH, AND THE

FAITH-BASED COMMUNITY. REPRESENTATIVES FROM UNION HOSPITAL PARTICIPATE ON

THIS COMMITTEE AND A UNION HOSPITAL CAREGIVER CHAIRED THE COMMITTEE IN

FISCAL YEAR 2021. THROUGH PARTICIPATION IN THIS COMMITTEE, UNION HOSPITAL

WORKS WITH ITS COMMUNITY PARTNERS TO PROMOTE EDUCATION AND AWARENESS OF

CANCER PREVENTION AND SCREENINGS AND COLLABORATES TO MEET OBJECTIVES SET

BY COMMUNITY PARTNERS.

FINALLY, UNION HOSPITAL CONTINUED TO RUN AN ACTIVE BREAST CANCER

SURVIVORS SUPPORT GROUP IN FISCAL YEAR 2021. DESPITE THE CORONAVIRUS

PANDEMIC'S IMPACT ON COMMUNITY EVENTS AND IN-PERSON MEETINGS, SIX VIRTUAL

BREAST CANCER SURVIVORS' SUPPORT GROUPS WERE HELD BETWEEN SEPTEMBER 2020

AND FEBRUARY 2021. UNION HOSPITAL CAREGIVERS ALSO CREATED AND DISTRIBUTED

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

FIFTY SURVIVORSHIP BAGS TO CANCER SURVIVORS ON NATIONAL CANCER SURVIVORS' DAY ON JUNE 6, 2021.

BEHAVIORAL HEALTH

UNION HOSPITAL WORKS TO ADDRESS BEHAVIORAL HEALTH ISSUES WITHIN ITS COMMUNITY THROUGH DIRECT PROGRAMMING AND COLLABORATION WITH COMMUNITY PARTNERS. UNION HOSPITAL HAS A 12-BED INPATIENT UNIT, AN OUTPATIENT PRACTICE, AND AN INTENSIVE OUTPATIENT PROGRAM FOR ADULTS STRUGGLING TO MANAGE MENTAL HEALTH DISORDERS. ALL THESE OFFERINGS SEEK TO ADDRESS THE PATIENTS' NEEDS HOLISTICALLY WITH A PERSON-CENTERED APPROACH THAT RELIES ON MULTI-DISCIPLINARY TEAMS.

UNION HOSPITAL CONTINUED THE PEER RECOVERY ADVOCATES PROGRAM IN COLLABORATION WITH THE CECIL COUNTY HEALTH DEPARTMENT IN FISCAL YEAR 2021. UNION HOSPITAL CAREGIVERS IDENTIFY INDIVIDUALS IN THE EMERGENCY DEPARTMENT AND THE PSYCHIATRIC UNIT WHO MAY SUFFER FROM A SUBSTANCE USE DISORDER AND THEN COORDINATE WITH THE PEER PROGRAM TO ENSURE THOSE INDIVIDUALS CONNECT WITH A PEER. THE PEER THEN WORKS TO IDENTIFY THE INDIVIDUAL'S NEEDS, GET THEM INTO TREATMENT, AND GET CONNECTED WITH THE APPROPRIATE COMMUNITY RESOURCES. IMPORTANTLY, THE PEERS REMAIN IN COMMUNICATION WITH THESE INDIVIDUALS TO ENSURE CONTINUED SUCCESS. 119 INDIVIDUALS WERE REFERRED TO THE PEER PROGRAM IN FISCAL YEAR 2021. UNFORTUNATELY, DUE TO THE PANDEMIC, PEERS WERE NOT PRESENT AT UNION HOSPITAL UNTIL MID-JUNE 2021.

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

PRIOR TO FISCAL YEAR 2020, UNION CAREGIVERS WOULD VOLUNTEER AT TWO TREATMENT PROVIDERS IN ELKTON, SERENITY HEALTH AND ELKTON TREATMENT CENTER. AT THESE LOCATIONS, CAREGIVERS WOULD PROVIDE EXPECTANT AND NEW MOTHERS WITH EDUCATION ON CARING FOR INFANTS AND NEONATAL ABSTINENCE SYNDROME (NAS). IN FISCAL YEAR 2020, THE DECISION WAS MADE TO PAY CAREGIVERS FOR THEIR TIME PROVIDING EDUCATION AT SERENITY HEALTH. DUE TO VERY LOW ATTENDANCE, THIS SERVICE WAS DISCONTINUED AT ELKTON TREATMENT CENTER. SERENITY HEALTH CLASSES WERE SUSPENDED IN THE LATTER MONTHS OF FISCAL YEAR 2020 DUE TO THE PANDEMIC, AND THESE CLASSES DID NOT RESUME UNTIL JUNE 2021. CAREGIVERS WERE ONLY ABLE TO PROVIDE ONE SESSION AT SERENITY HEALTH PRIOR TO THE CLOSE OF THE FISCAL YEAR 2021.

CHILDHOOD TRAUMA

SOME EFFORTS TO ADDRESS CHILDHOOD TRAUMA HAVE BEEN MENTIONED PREVIOUSLY SUCH AS PARTICIPATION ON THE LOCAL MANAGEMENT BOARD OF CECIL COUNTY WHICH SERVES AS THE COORDINATOR OF COLLABORATION FOR CHILD AND FAMILY SERVICES AND THE NAS PARENTING EDUCATION PROVIDED AT SERENITY HEALTH.

UNION HOSPITAL ALSO SUPPORTS THE CHILD ADVOCACY CENTER (CAC), AN ORGANIZATION WHOSE MISSION IS TO PARTNER FOR BETTER INVESTIGATION AND ASSESSMENT OF ABUSE ALLEGATIONS, PROSECUTION OF OFFENDERS, AND TREATMENT FOR CHILDREN AND FAMILIES IMPACTED BY CHILD ABUSE AND NEGLECT. THE CAC IS A COLLABORATION OF AGENCIES THAT FACILITATE MULTIDISCIPLINARY TEAM

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

INVESTIGATIONS OF CHILD MALTREATMENT AND OFFERS DIRECT SERVICES TO THE CHILD AND FAMILY DURING AND AFTER THE INVESTIGATION. IN FISCAL YEAR 2021, A REGISTERED NURSE ATTENDED SEVERAL MEETINGS OF THE CAC TO PROVIDE HER EXPERTISE.

BELOW IS A TABLE DESCRIBING THE HEALTH NEEDS OF THE COMMUNITY THAT WERE IDENTIFIED IN THE 2019 CHNA, BUT NOT PRIORITIZED BECAUSE THE RESOURCES TO DO SO DID NOT EXIST OR CONVERSELY, A COMMUNITY FOCUS ON THIS NEED ALREADY EXISTS (2019 CHNA, PAGE 27-30).

SCHEDULE H, PART V, SECTION B, LINE 11 (ADDRESSING NEEDS FROM THE CHNA)

HEALTH NEEDS IDENTIFIED BUT NOT PRIORITIZED:

- ACCESS TO CARE: ONGOING EFFORTS THROUGH HEALTH SERVICES TO BRING MORE PROVIDERS INTO THE COMMUNITY COVERING A RANGE OF SPECIALTIES, INCLUDING PRIMARY CARE AND GERIATRIC SERVICES.

- HOMELESSNESS: CHAC DOES NOT HAVE ENOUGH RESOURCES TO MANAGE THIS PROBLEM. HOMELESS PROVIDERS IN THE AREA MEET THROUGH THE CECIL COUNTY INTERAGENCY COUNCIL ON HOMELESSNESS TO WORK THROUGH ISSUES AND FIND ADDITIONAL SUPPORTS.

- CHRONIC DISEASE: CHRONIC DISEASES IDENTIFIED: ARTHRITIS, ASTHMA, COPD, HEART DISEASE, HYPERTENSION, OBESITY, STROKE, AND DIABETES. WHILE

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

RESOURCE CONSTRAINTS LIMIT THE ABILITY TO IMPLEMENT TARGETED PROGRAMS,
THERE ARE ONGOING EFFORTS THROUGH HEALTH SERVICES TO BRING MORE PROVIDERS
INTO THE COMMUNITY COVERING A RANGE OF SPECIALTIES, INCLUDING PRIMARY
CARE AND GERIATRIC SERVICES.

- DENTAL HEALTH: WITH THE DENTAL CLINIC CLOSURE, STARTING A NEW EFFORT TO
MANAGE DENTAL HEALTH NEEDS IN VULNERABLE COMMUNITIES WAS NOT FEASIBLE.
THE DENTAL ADVISORY COMMITTEE IS CURRENTLY WORKING ON STRATEGIES TO
INCREASE AWARENESS AROUND DENTAL HEALTH IN VULNERABLE AND UNDERSERVED
NEIGHBORHOODS, PRIMARILY WORKING THROUGH NEIGHBORHOOD COMMUNITY CENTERS
AND LOCAL LIBRARIES.

- TOBACCO USE: TOBACCO USE IS A RISK FACTOR THAT IS ADDRESSED THROUGH
PROGRAMS AT THE CECIL COUNTY HEALTH DEPARTMENT AND THROUGH THE MARYLAND
QUITLINE.

- INFECTIOUS & COMMUNICABLE DISEASES: THERE ARE PROGRAMS IN PLACE THROUGH
THE CECIL COUNTY HEALTH DEPARTMENT TO ADDRESS INFECTIOUS AND COMMUNICABLE
DISEASE.

- VACCINATION: ADDRESSED BY THE SCHOOLS, CECIL COUNTY HEALTH DEPARTMENT,
UNION HOSPITAL, AND PHYSICIAN PRACTICES.

- ENVIRONMENTAL HEALTH: ADDRESSED BY DEPT OF NATURAL RESOURCES AND CECIL
COUNTY HEALTH DEPT. LACK OF AVAILABLE RESOURCES; TOO BROAD.

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

- INJURIES MOTOR VEHICLE/PEDESTRIAN: ADDRESSED BY LAW ENFORCEMENT AND THE DEPT OF TRANSPORTATION.

- CHILD ABUSE AND NEGLECT: HANDLED THROUGH REPORTS TO CPS AND MEDICAL EXAMS FROM THE CECIL COUNTY CHILD ADVOCACY CENTER

- DOMESTIC VIOLENCE: ADDRESSED BY THE DOMESTIC VIOLENCE SHELTER, A PART OF THE DEPARTMENT OF SOCIAL SERVICES, AND LOCAL LAW ENFORCEMENT

- VIOLENT CRIME: ADDRESSED BY LOCAL AND STATE LAW ENFORCEMENT IN CECIL COUNTY. AGENCIES AND HEALTH CARE SERVICES ALSO PARTNER WITH LAW ENFORCEMENT TO SUPPORT THEIR EFFORTS.

- SUICIDE: ADDRESSED THROUGH INPATIENT AND OUTPATIENT PROGRAMS IN THE COMMUNITY, MEDIATION SERVICES LIKE EASTERN SHORE MOBILE CRISIS, UPPER BAY COUNSELING SERVICES, AND HOT- AND WARM-LINES PROVIDING REAL-TIME INTERVENTIONS TO THOSE AT-RISK FOR SUICIDE.

BARRIERS TO CARE IDENTIFIED BUT NOT PRIORITIZED:

- INCOME & POVERTY: MAY BE ADDRESSED AS PART OF EACH OF THE HEALTH PRIORITY AREAS. REQUIRES STRONGER GOVERNMENT/PUBLIC PROGRAMS AND AND FUNDING TO SUPPORT OVERCOMING THESE BARRIERS.

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

- EMPLOYMENT: MAY BE ADDRESSED AS PART OF THE BEHAVIORAL HEALTH PRIORITY.

OTHERWISE ADDRESSED BY SUSQUEHANNA WORKFORCE NETWORK, CECIL COLLEGE, AND

OTHER LOCAL NON-PROFITS, LIKE THOSE THAT ASSIST VETERANS.

- HEALTH INSURANCE AVAILABILITY AND COST: ADDRESSED THROUGH THE MARYLAND HEALTH CONNECTION AND SEEDCO.

- TRANSPORTATION: ADDRESSED THROUGH VOUCHER PROGRAMS AT DEPT OF COMMUNITY SERVICES AND THROUGH LOCAL PARTNERSHIPS.

- HEALTH CARE COSTS: ADDRESSED THROUGH PROGRAMS LIKE: UNION HOSPITAL COMMUNITY ASSISTED MEDICATION PROGRAM (CAMP), THE UNION HOSPITAL CANCER PROGRAM COMMUNITY OUTREACH SUPPORT, MANY OUTREACH PROGRAMS AT THE CECIL COUNTY HEALTH DEPARTMENT, LOCAL PHARMACY ASSISTANCE PROGRAMS, AND THE DEPARTMENT OF COMMUNITY SERVICES ASSISTANCE PROGRAMS THROUGH MAPP, OPTIONS COUNSELING, AND COMMUNITY FIRST CHOICE.

- HOME HEALTH ELIGIBILITY: ADDRESSED THROUGH PROGRAMS THAT ASSIST PERSONS WITH THE APPLICATION PROCESS (EX. THE COUNTY DEPARTMENT OF COMMUNITY SERVICES).

- LACK OF KNOWLEDGE (INCL. LOW HEALTH LITERACY, LACK OF ACCESS TO HEALTH INFORMATION): OPPORTUNITIES TO ADDRESS HEALTH LITERACY ARE BEING EXPLORED FOR ALL PRIORITY AREAS.

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

- PUBLIC ASSISTANCE QUALIFICATIONS: ADDRESSED THROUGH CECIL COUNTY HEALTH DEPARTMENT, THE DEPARTMENT OF COMMUNITY SERVICES, THE DEPARTMENT OF SOCIAL SERVICES, AND THE CERTIFIED HEALTH INSURANCE NAVIGATORS THROUGH SEEDCO AND THE MARYLAND HEALTH CONNECTION.

- NEED FOR MORE MEDICAL AND SOCIAL SUPPORTS: ADDRESSED BY DEPT OF SOCIAL SERVICES, DEPT OF COMMUNITY SERVICES, CECIL COUNTY HEALTH DEPARTMENT, AND OTHER SOCIAL SERVICES.

- EDUCATIONAL ATTAINMENT: ADDRESSED BY LOCAL NON-PROFITS WORK WITH SPECIAL AND VULNERABLE POPULATIONS WHO EXPERIENCE BARRIERS TO GETTING A GED; LOCAL FEDERAL CREDIT UNIONS PROVIDE EDUCATION ON HOW TO AFFORDABLY FINANCE EDUCATION; CECIL COLLEGE OFFERS SCHOLARSHIPS TO ELIGIBLE INDIVIDUALS; AND WORKPLACES PROVIDE TUITION REIMBURSEMENT FOR APPLICABLE EDUCATIONAL ATTAINMENT (E.G. WORKPLACE CERTIFICATIONS OR DEGREES).

- AFFORDABLE HOUSING: AFFORDABLE HOUSING IS A LARGE BARRIER IN CECIL COUNTY, ESPECIALLY AMONG THE POOR AND LOW-INCOME. WHILE WAIT LISTS ARE LONG FOR MOST HOUSING PROGRAMS, THERE ARE AGENCIES IN THE COMMUNITY THAT MANAGE THIS ISSUE. ALSO, WHILE NEW DEVELOPMENT IS COSTLY, THERE ARE SOME RESOURCES AVAILABLE TO PURCHASE AND/OR REHAB EXISTING OR NEW PROPERTIES FOR TRANSITIONAL HOUSING. SOME COMMUNITY WORK HAS BEEN DONE TO STRIKE COMPROMISES WITH LANDLORDS TO HOUSE HOMELESS AND OTHER TENANTS WHO CAN DEMONSTRATE THE ABILITY TO SUSTAIN HOUSING.

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

- LANGUAGE BARRIERS: LANGUAGE BARRIERS CAN BE ADDRESSED THROUGH THE USE OF INTERPRETERS. MOST PROGRAMS IN THE COUNTY HAVE ACCESS TO MEDICAL AND SOCIAL INTERPRETERS OR CONTRACTED INTERPRETER SERVICES. IF ACCESS IS A PROBLEM THEN THERE IS OPPORTUNITY TO PARTNER WITH ORGANIZATIONS THAT HAVE THESE RESOURCES. FOR PATIENTS OR CLIENTS WITH LANGUAGE BARRIERS THERE IS OPPORTUNITY FOR ORGANIZATIONS TO PROVIDE MATERIALS IN OTHER LANGUAGES AND HIRE OR ACCESS PROFESSIONALS THAT CAN SPEAK OTHER LANGUAGES.

- TIME LIMITATIONS: IN ALL THE FOCUS GROUPS IT WAS VOICED THAT THERE ARE NOT ENOUGH DOCTORS' OFFICES OPEN IN THE EVENING HOURS. UNION HOSPITAL AND MANY OTHER PROVIDERS IN THE COMMUNITY HAVE ADDED EVENING AND WEEKEND HOURS FOR FREQUENTLY USED SERVICES, LIKE PRIMARY CARE AND URGENT CARE.

SCHEDULE H, PART V, SECTION B, LINE 13B (DETAIL OF INCOME LEVEL)

PATIENTS WITH A HOUSEHOLD INCOME UP TO 500% OF FPL AND WITH A FINANCIAL HARDSHIP (MEDICAL DEBT, INCURRED BY A FAMILY OVER A 12-MONTH PERIOD THAT EXCEEDS 25 PERCENT OF THE FAMILY INCOME) WILL RECEIVE A 25% ADJUSTMENT.

SCHEDULE H, PART V, SECTION B, LINE 16A (FAP AVAILABILITY)

FAP WEBSITE:

[HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/](https://www.uhcc.com/patient-financial-services/financial-assistance/)

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SCHEDULE H, PART V, SECTION B, LINE 16B (FAP APPLICATION AVAILABILITY)

FAP APPLICATION WEBSITE:

[HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/](https://www.uhcc.com/patient-financial-services/financial-assistance/)

SCHEDULE H, PART V, SECTION B, LINE 16C (FAP PLS AVAILABILITY)

FAP PLAIN LANGUAGE SUMMARY WEBSITE:

[HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL-SERVICES/FINANCIAL-ASSISTANCE/](https://www.uhcc.com/patient-financial-services/financial-assistance/)

SCHEDULE H, PART V, SECTION B, LINE 16J (FAP OTHER AVAILABILITY)

UNION HOSPITAL PLACES AN ADVERTISEMENT ONCE A YEAR IN THE LOCAL NEWSPAPERS OUTLINING THE FAP AND HOW TO APPLY. FAP IS PUBLICIZED ON ALL BILLING STATEMENTS, INVOICES, AND FINANCIAL CONSENT FORMS. FAP IS COMMUNICATED TO PATIENTS UPON DISCHARGE FROM INPATIENT, OBSERVATION, AND SURGICAL SERVICES.

Part V Facility Information (continued)

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? _____

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 7 (BAD DEBT EXPENSE, COSTING METHODOLOGY USED)

IMPLICIT PRICE CONCESSIONS ARE TREATED AS A CONTRA-REVENUE ITEM ON THE STATEMENT OF REVENUE. AS A RESULT, THERE ARE NO BAD DEBT EXPENSES INCLUDED ON FORM 990, PART IX THAT NEED TO BE SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGES LISTED.

THE COSTING METHODOLOGY USED IN CALCULATING THE AMOUNTS REPORTED ON THE LINE 7 TABLE ARE BASED ON ACTUAL COST PLUS OVERHEAD. OVERHEAD IS A HOSPITAL AVERAGE PERCENTAGE OF OVERHEAD TO DIRECT COSTS. DIRECT COSTS EXCLUDE BAD DEBT EXPENSE.

PART II (DETAIL OF COMMUNITY BUILDING ACTIVITIES)

IN FISCAL YEAR 2021, UNION HOSPITAL PARTICIPATED IN ECONOMIC DEVELOPMENT COMMUNITY BUILDING ACTIVITIES THROUGH THE PARTICIPATION OF ITS PRESIDENT, SHARON KURFUERST, ON THE BOARD OF THE ECONOMIC DEVELOPMENT COMMISSION FOR

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

CECIL COUNTY. THE ECONOMIC DEVELOPMENT COMMISSION FOCUSES ON BUSINESS AND INDUSTRY DEVELOPMENT BY BUILDING RELATIONSHIPS WITH LOCAL PARTNERS IN CECIL COUNTY.

IN FISCAL YEAR 2021, PRESIDENT KURFUERST ALSO PARTICIPATED IN COMMUNITY SUPPORT COMMUNITY BUILDING ACTIVITIES BY ATTENDING HER FIRST MEETING OF THE LOCAL MANAGEMENT BOARD OF CECIL COUNTY. THE CORE FUNCTION OF LOCAL MANAGEMENT BOARDS (LMBS) IS TO IDENTIFY COMMUNITY DRIVEN PRIORITIES AND TARGET RESOURCES FOR THEIR COMMUNITIES, AS WELL AS SERVE AS THE COORDINATOR OF COLLABORATION FOR CHILD AND FAMILY SERVICES. THERE IS A LOCAL MANAGEMENT BOARD IN EACH COUNTY IN MARYLAND, INCLUDING BALTIMORE CITY.

PART III, SECTION A, LINE 2 (IMPLICIT PRICE CONCESSIONS/BAD DEBT EXPENSE)

THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNTS REPORTED ON LINES 2 AND 3 ARE BASED ON ACTUAL CHARGES WRITTEN OFF (AMOUNTS THAT ARE DEEMED

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

TO BE UNCOLLECTIBLE AND RECORDED AS IMPLICIT PRICE CONCESSIONS UNDER
ACCOUNTING PRONOUNCEMENT ASC 606) TIMES THE COST TO CHARGE RATIO.

PART III, SECTION A, LINE 3 (IMPLICIT PRICE CONCESSION METHODOLOGY)

THE IMPLICIT PRICE CONCESSION METHODOLOGY ASSUMES THAT THE PERCENTAGE OF
CHARITY CARE TO TOTAL REVENUE CAN BE APPLIED TO THE AMOUNT OF IMPLICIT
PRICE CONCESSIONS FOR THE YEAR. OTHER IMPLICIT PRICE CONCESSION AMOUNTS
ARE NOT INCLUDED IN COMMUNITY BENEFITS.

PART III, SECTION A, LINE 4 (IMPLICIT PRICE CONCESSION FOOTNOTE)

THE TEXT OF THE IMPLICIT PRICE CONCESSION (BAD DEBT EXPENSE) FOOTNOTE CAN
BE FOUND ON PAGE 15 OF THE ELECTRONICALLY ATTACHED AUDITED FINANCIAL
STATEMENTS.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART III, SECTION B, LINE 8 (COSTING METHODOLOGY, MEDICARE SHORTFALL)

COSTING METHODOLOGY USED TO DETERMINE AMOUNT OF MEDICARE ALLOWABLE COSTS:

MEDICARE ALLOWABLE COSTS EQUAL MEDICARE REVENUE ADJUSTED FOR THE HOSPITAL

TOTAL RATIO OF PATIENT CARE COSTS TO CHARGES DUE TO THE FACT THAT

MEDICARE PAYS FULL CHARGES IN MARYLAND.

EXTENT TO WHICH MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY

BENEFIT: IN THE STATE OF MARYLAND, MEDICARE PAYS FULL CHARGES. THERE IS

NO SHORTFALL THAT SHOULD BE TREATED AS A COMMUNITY BENEFIT.

PART III, SECTION B, LINE 9B (COLLECTION PRACTICES)

UNION HOSPITAL'S F-416 CREDIT AND COLLECTION POLICY AND PROCEDURE HAS A

SECTION CALLED, "INTERNAL COLLECTION EFFORTS" WHICH STATES: "UPON

DISCHARGE, PATIENTS RECEIVE AN ITEMIZED BILL FOR INPATIENT ADMISSIONS IN

ACCORDANCE WITH THE MARYLAND HOSPITAL COST REVIEW COMMISSION

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

REQUIREMENTS. WHEN INSURANCE PAYMENTS ARE RECEIVED LEAVING A SELF-PAY BALANCE, OR THE ACCOUNT IS STRICTLY SELF-PAY, IT IS OUTSOURCED FOR FOLLOW-UP BUT REMAINS ON THE HOSPITAL'S ACTIVE ACCOUNTS RECEIVABLE. AGENTS WORK THE ACCOUNTS IN THE HOSPITAL'S NAME AND REPRESENTATIVES ARE DIRECTED TO ACCEPT MONTHLY PAYMENTS UNTIL THE ACCOUNT IS PAID IN FULL. COLLECTION EFFORTS CONSIST OF PHONE CALLS AND MONTHLY STATEMENTS. THE PATIENT MAY ALSO APPLY FOR FINANCIAL ASSISTANCE AT ANY TIME DURING THIS PROCESS (SEE POLICY F-415, FINANCIAL ASSISTANCE)." IN THE F-415 FINANCIAL ASSISTANCE POLICY AND PROCEDURE, UNDER SECTION, "ACTION IN THE EVENT OF NON-PAYMENT," IT IS EXPLAINED THAT: "A. UNION HOSPITAL MAY CONTRACT WITH OUTSIDE COLLECTION SERVICES TO PURSUE COLLECTION OF DELINQUENT ACCOUNTS. ALL UNPAID ACCOUNTS WITHOUT EXCEPTION OR PAYMENT ARRANGEMENTS ARE PLACED IN OUTSIDE COLLECTION AFTER A MINIMUM OF 90 DAYS FROM THE INITIAL BILLING STATEMENT AND DELIVERY OF ALL SCHEDULED PATIENT ACCOUNT STATEMENTS TO THE PATIENT/GUARANTOR. B. UNION HOSPITAL DOES NOT CONDUCT, OR PERMIT COLLECTION AGENCIES TO CONDUCT ON THEIR BEHALF, EXTRAORDINARY COLLECTIONS EFFORTS AGAINST INDIVIDUALS."

Part VI Supplemental Information

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- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

IN ADDITION, IN THE F-416 POLICY, UNDER THE SECTION, "EXTERNAL COLLECTION (BAD DEBT WRITE-OFF)," IT EXPLAINS THAT PATIENTS WITH BALANCES BEING COLLECTED BY AN ASSIGNED COLLECTION AGENCY WILL HAVE THEIR BALANCES WRITTEN OFF IF THEY ARE DETERMINED TO BE INDIGENT.

PART VI, LINE 2 (NEEDS ASSESSMENT)

UNION HOSPITAL ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITIES IT SERVES THROUGH ITS ROBUST COMMUNITY PARTNERSHIPS. PERHAPS ITS MOST SIGNIFICANT PARTNERSHIPS ARE WITH THE CECIL COUNTY HEALTH DEPARTMENT (CCHD) AND THE COMMUNITY HEALTH ADVISORY COMMITTEE (CHAC). UNION HOSPITAL HAS PARTNERED WITH THE CCHD TO CONDUCT AND COMPLETE ITS NEEDS ASSESSMENTS SINCE 2013. THE CHAC ALSO PLAYS A SIGNIFICANT ROLE IN THIS PROCESS AS IT PROVIDES SUBSTANTIAL INPUT ON THE SELECTION OF THE PRIORITIZED NEEDS, AND IT GOVERNS THE HEALTH TASK FORCES THAT WORK ON AND MONITOR PROGRESS MADE ON THE CHIP THAT ADDRESS THE HEALTH PRIORITIES IDENTIFIED IN THE CHNA. THE CCHD IS INVOLVED IN MANY HEALTH INITIATIVES THROUGHOUT CECIL COUNTY

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AND THE CHAC IS COMPRISED OF SEVERAL LOCAL GOVERNMENT AND COMMUNITY ORGANIZATIONS. THESE PARTNERSHIPS PROVIDE UNION HOSPITAL WITH RICH INSIGHT INTO THE HEALTH OF OUR COMMUNITY.

AS DESCRIBED PREVIOUSLY, UNION HOSPITAL WILL CONTINUE TO RELY UPON THE COMMUNITY KNOWLEDGE AND PARTNERSHIPS OF THE CCHD AND THE CHAC, BUT IN THE FUTURE, UNION HOSPITAL WILL PRIORITIZE AREAS OF NEED BASED ON COMMUNITY INPUT AND ITS ABILITY TO ADDRESS AREAS OF NEED. UNION HOSPITAL WILL ALSO DESIGN ITS CHIP TO INCLUDE SPECIFIC ACTIVITIES UNION HOSPITAL WILL UNDERTAKE INDEPENDENTLY AND IN COLLABORATION WITH COMMUNITY PARTNERSHIPS.

UNION HOSPITAL CAREGIVERS ALSO PARTICIPATE IN DIFFERENT COMMUNITY BOARDS AND COMMITTEES THAT FOCUS ON DIFFERENT AREAS OF COMMUNITY NEED AND INTEREST. BESIDES THE ONES MENTIONED IN PRIOR SECTIONS:

- CHILD ADVOCACY CENTER
- ECONOMIC DEVELOPMENT COMMISSION

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- LOCAL MANAGEMENT BOARD OF CECIL COUNTY

IN FISCAL YEAR 2021, UNION HOSPITAL ALSO PARTICIPATED IN THESE ADDITIONAL GROUPS:

- ADULT DISABILITY RESOURCE COMMITTEE
- ROTARY CLUB OF ELKTON

IN JANUARY 2020, UNION HOSPITAL BECAME A PART OF CHRISTIANACARE. CHRISTIANACARE IS ONE OF THE COUNTRY'S MOST DYNAMIC HEALTH CARE ORGANIZATIONS, CENTERED ON IMPROVING HEALTH OUTCOMES, MAKING HIGH-QUALITY CARE MORE ACCESSIBLE AND LOWERING HEALTH CARE COSTS. CHRISTIANACARE ALSO ABIDES BY THE CHRISTIANACARE WAY: WE SERVE OUR NEIGHBORS AS RESPECTFUL, EXPERT, CARING PARTNERS IN THEIR HEALTH. WE DO THIS BY CREATING INNOVATIVE, EFFECTIVE, AFFORDABLE SYSTEMS OF CARE THAT OUR NEIGHBORS VALUE. CHRISTIANACARE IS GUIDED BY ITS COMMITMENT TO PARTNERING WITH OUR NEIGHBORS TO BETTER UNDERSTAND THEIR NEEDS AND GOALS FOR HEALTH.

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PART VI, LINE 3 (PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE)

UNION HOSPITAL OF CECIL COUNTY UTILIZES A FINANCIAL ASSISTANCE POLICY (FAP) TO ENSURE THAT THE HOSPITAL'S STAFF FOLLOWS A CONSISTENT AND EQUITABLE PROCESS IN GRANTING FINANCIAL ASSISTANCE TO PATIENTS, WHILE RESPECTING THE INDIVIDUAL'S DIGNITY. THE POLICY ADHERES TO THE ESTABLISHED MARYLAND STATE FINANCIAL ASSISTANCE GUIDELINES.

THE FAP CLEARLY DEFINES PATIENT EXPECTATIONS, OFFERS A STEP-BY-STEP PROCESS FOR PATIENT APPLICATION, DOCUMENT REVIEW, AND REQUEST FOR MORE INFORMATION. INDIVIDUALS WHO PRESENT TO UNION HOSPITAL IN PERSON TO DISCUSS A BILL ARE PROVIDED WITH A FINANCIAL ASSISTANCE APPLICATION. ALL INPATIENT, SELF-PAY PATIENTS ARE VISITED BY FINANCIAL ASSISTANCE NAVIGATORS AND ARE SCREENED FOR THE FINANCIAL ASSISTANCE PROGRAM, AS WELL AS FOR MEDICAID AND OTHER STATE AND COUNTY PROGRAMS. FOLLOWING DISCHARGE FROM THE HOSPITAL, EACH PATIENT RECEIVES A SUMMARY OF CHARGES WHICH INCLUDES NOTICE OF THE FINANCIAL ASSISTANCE PROGRAM AND A DESIGNATED CONTACT TELEPHONE NUMBER AND EMAIL. PATIENT BILLING ALSO INCLUDES

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INFORMATION ON HOW TO APPLY FOR FINANCIAL ASSISTANCE.

THE FINANCIAL ASSISTANCE APPLICATION IS AVAILABLE TO ALL UNDERINSURED AND UNINSURED PATIENTS OF UNION HOSPITAL. ALL FINANCIAL ASSISTANCE APPLICATIONS RECEIVED ARE PROCESSED FOR ELIGIBILITY. PATIENTS WHO ARE NOT ELIGIBLE FOR FINANCIAL ASSISTANCE ARE REFERRED TO THE CECIL COUNTY HEALTH DEPARTMENT, OTHER STATE PROGRAMS, THE MARYLAND HEALTH CONNECTION, AND MEDICAID TO DETERMINE IF OTHER ASSISTANCE IS AVAILABLE.

FINANCIAL ASSISTANCE APPLICATIONS AND FAP SIGNAGE ARE LOCATED THROUGHOUT THE HOSPITAL, EMERGENCY ROOM, AND OUTPATIENT AREAS. THE FINANCIAL ASSISTANCE APPLICATION AND BROCHURE (ENGLISH AND SPANISH) ARE AVAILABLE ON THE HOSPITAL'S WEBSITE:

[HTTPS://WWW.UHCC.COM/PATIENT-FINANCIAL SERVICES/FINANCIAL-ASSISTANCE/](https://www.uhcc.com/patient-financial-services/financial-assistance/)

IN ADDITION, UNION HOSPITAL PLACES AN ADVERTISEMENT ONCE A YEAR IN THE LOCAL NEWSPAPERS OUTLINING THE FAP, HOW TO ACCESS FINANCIAL ASSISTANCE MATERIALS, AND HOW TO APPLY FOR FINANCIAL ASSISTANCE.

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PART VI, LINE 4 (COMMUNITY INFORMATION)

UNION HOSPITAL IS THE ONLY HOSPITAL IN CECIL COUNTY AND SERVES THE ENTIRE COUNTY. CECIL COUNTY IS IN THE UPPER NORTHEASTERN CORNER OF THE CHESAPEAKE BAY IN MARYLAND AND BORDERS PENNSYLVANIA AND DELAWARE. THE COUNTY SEAT IS ELKTON, MARYLAND, AND THERE ARE EIGHT TOWNS AND SEVEN UNINCORPORATED COMMUNITIES IN THE COUNTY.

PRIMARY SERVICE AREA

21921 - ELKTON

21922 - ELKTON

21901 - NORTH EAST

21916 - CHILDS

21920 - ELK MILLS

21915 - CHESAPEAKE CITY

21914 - CHARLESTOWN

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21911 - RISING SUN

21912 - WARWICK

21913 - CECILTON

21919 - EARLEVILLE

SECONDARY SERVICE AREA

21902 - PERRYPOINT

21903 - PERRYVILLE

21904 - PORT DEPOSIT

21917 - COLORA

21918 - CONOWINGO

21930 - GEORGETOWN

THE LARGEST POPULATION CENTERS IN CECIL COUNTY ARE ELKTON (21921), NORTH EAST, AND RISING SUN. HOSPITAL UTILIZATION SHOWS THAT 60% OF THE HOSPITAL'S PATIENTS COME FROM ELKTON AND NORTH EAST.

ACCORDING TO THE DEPARTMENT OF PLANNING, MARYLAND STATE DATA CENTER, IN

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2020 THE CECIL COUNTY POPULATION WAS 101,352. IN TERMS OF AGE, THE LARGEST COHORT ARE THOSE AGED 18 TO 44 YEARS. THE 65 + POPULATION IS EXPECTED TO GROW BY 43% BY 2030.

CECIL COUNTY IS LESS RACIALLY DIVERSE THAN MARYLAND AND THE UNITED STATES WITH ONLY 7.4% OF ITS POPULATION IDENTIFYING AS AFRICAN AMERICAN AND 4.5% IDENTIFYING AS HISPANIC. CECIL COUNTY'S POVERTY RATE IS 9.8% AND 10.5% OF ITS POPULATION HAVE LESS THAN A HIGH SCHOOL DIPLOMA. THESE ARE LOWER RATES THAN THE UNITED STATES, BUT HIGHER RATES THAN MARYLAND. (HEALTH RESOURCES AND SERVICES ADMINISTRATION. 2015-2019. "UDS MAPPER" (WEB APPLICATION) (HTTP://WWW.UDSMAPPER.ORG)).

PART VI, LINE 5 (INFORMATION REGARDING PROMOTION OF COMMUNITY HEALTH)

CHRISTIANACARE, UNION HOSPITAL JOINED CHRISTIANACARE IN JANUARY 2020, AT WHICH TIME WE FOCUSED ON THE INTEGRATION OF UNION INTO THE LARGER HEALTH SYSTEM. SHORTLY THEREAFTER, IN MARCH 2020, THE CORONAVIRUS PANDEMIC WAS

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DECLARED. WHILE CONTINUING OUR INTEGRATION WORK, WE AT THE SAME TIME SHIFTED OUR FOCUS TO RESPONDING TO THE PANDEMIC AND ENSURING WE WERE SERVING OUR COMMUNITIES BY PROVIDING TESTING, VACCINATION, COVID CARE, PREVENTION, AND EDUCATION. A HIGHLIGHT OF FISCAL YEAR 2021 WAS THE INTRODUCTION OF COVID-19 VACCINATIONS. UNION HOSPITAL HOSTED 196 VACCINATION CLINICS BEGINNING ON DECEMBER 21, 2020. UNION HOSPITAL CAREGIVERS ALSO PARTICIPATED IN COMMUNITY VACCINATION EVENTS LIKE THE CECIL COUNTY FAIR AND NATIONAL NIGHT OUT IN COLLABORATION WITH THE CCHD AS WELL AS WORKED WITH LARGE LOCAL BUSINESSES TO PROVIDE VACCINATIONS AT LOCATIONS IN THE COMMUNITY. UNION HOSPITAL ALSO HOSTED 26 VACCINATION CLINICS AT CECIL COUNTY PUBLIC SCHOOLS. IN FISCAL YEAR 2021, UNION HOSPITAL PROVIDED A TOTAL OF 30,841 VACCINATIONS TO COMMUNITY MEMBERS. 20,659 OF THOSE VACCINATIONS WERE FIRST DOSES.

AS WE CONTINUED TO WORK ON INTEGRATING UNION HOSPITAL INTO CHRISTIANACARE AND SERVE OUR COMMUNITY WITH OVER 200 VACCINATION CLINICS, MANY OF THE COMMUNITY BENEFIT ACTIVITIES TYPICALLY UNDERTAKEN, LIKE COMMUNITY CANCER SCREENINGS AND STUDENT EDUCATION AT UNION HOSPITAL, HAD TO BE CANCELLED

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DUE TO THE PANDEMIC. AS WE DEVELOP OUR COMMUNITY HEALTH IMPROVEMENT PLAN BASED ON THE 2022 CHNA WE ARE CURRENTLY UNDERTAKING, WE WILL CONSIDER HOW WE CAN DESIGN PROGRAMMING AND ACTIVITIES THAT CAN CONTINUE DESPITE POTENTIAL OUTBREAKS IN THE FUTURE.

GUIDED BY THE CHRISTIANACARE WAY AND OUR VALUES OF LOVE AND EXCELLENCE, CHRISTIANACARE INCLUDES AN EXTENSIVE NETWORK OF OUTPATIENT SERVICES, HOME HEALTH CARE, URGENT CARE CENTERS, THREE HOSPITALS (1,299 BEDS), A FREE STANDING EMERGENCY DEPARTMENT, A LEVEL I TRAUMA CENTER AND A LEVEL III NEONATAL INTENSIVE CARE UNIT, A COMPREHENSIVE STROKE CENTER AND REGIONAL CENTERS OF EXCELLENCE IN HEART AND VASCULAR CARE, CANCER CARE AND WOMEN'S HEALTH. IT ALSO INCLUDES THE PIONEERING GENE EDITING INSTITUTE AND WAS RATED BY IDG COMPUTERWORLD AS ONE OF THE NATION'S BEST PLACES TO WORK IN IT. CHRISTIANACARE IS A NONPROFIT TEACHING HEALTH SYSTEM WITH MORE THAN 260 RESIDENTS AND FELLOWS. IT IS CONTINUALLY RANKED BY U.S. NEWS & WORLD REPORT AS A BEST HOSPITAL. WITH THE UNIQUE CAREVIO DATA-POWERED CARE COORDINATION SERVICE AND A FOCUS ON POPULATION HEALTH AND VALUE-BASED CARE, CHRISTIANACARE IS SHAPING THE FUTURE OF HEALTH CARE.

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EACH FISCAL YEAR, UNION HOSPITAL SERVES THE CECIL COUNTY COMMUNITY BY PROVIDING ACTIVITIES, PROGRAMS, AND INITIATIVES THAT SEEK TO IMPROVE COMMUNITY HEALTH, ESPECIALLY SERVING UNDERSERVED AREAS AND VULNERABLE POPULATIONS. THE FOLLOWING IS A SUMMARY OF THE COMMUNITY BENEFIT ACTIVITIES, PROGRAMS, AND INITIATIVES THAT UNION HOSPITAL PROVIDED IN CECIL COUNTY DURING FISCAL YEAR 2021 THAT HAVE NOT BEEN MENTIONED PREVIOUSLY IN THIS NARRATIVE:

A1: COMMUNITY HEALTH EDUCATION

UNION HOSPITAL PROVIDED:

- HEALTH EDUCATION PRESENTATIONS IN THE COMMUNITY ON TOPICS SUCH AS DIABETES, BREAST CANCER, AND NUTRITION

A2: COMMUNITY-BASED CLINICAL SERVICES

- FREE FOOT AND EYE SCREENINGS FOR DIABETICS
 - TWO FREE SPORTS PHYSICALS CLINIC FOR COUNTY PUBLIC AND PRIVATE MIDDLE SCHOOL AND HIGH SCHOOL STUDENTS

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A4: SOCIAL AND ENVIRONMENTAL IMPROVEMENTS

- TRANSPORTATION DONATIONS FOR ELIGIBLE (NEEDS-BASED) PATIENTS AND THEIR FAMILIES

B1-B3: HEALTH PROFESSIONS EDUCATION

- UNION HOSPITAL STAFF OFFERED TRADITIONAL CLINICAL ROTATIONS AND SENIOR PRECEPTORSHIPS TO 158 STUDENTS.

C: MISSION DRIVEN HEALTH SERVICES

- UNION HOSPITAL PROVIDED SUBSIDIZED OUTPATIENT SERVICES TO MEET IDENTIFIED NEEDS IN THE COMMUNITY, EVEN THOUGH THEY OPERATE AT A LOSS. THESE INCLUDE SERVICES LIKE PRIMARY CARE AND RHEUMATOLOGY

D1: CLINICAL RESEARCH

- MAINTAINED A CANCER REGISTRY THROUGH THE CANCER PROGRAM THAT WAS AVAILABLE TO HEALTH SERVICE PROVIDERS AND RESEARCHERS.

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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

E3: IN-KIND CONTRIBUTIONS

UNION HOSPITAL PROVIDED DONATIONS OF TIME AND MATERIALS FOR THE CECIL COUNTY COMMUNITY BY:

- PROVIDING FREE AMBULANCE TRANSPORTS AND FREE SUPPLIES FOR AMBULANCE STOCK-UPS
- PROVIDING FREE NOTARY SERVICES FOR THE COMMUNITY

DURING FISCAL YEAR 2021, UNION HOSPITAL ADAPTED TO OPERATE WITHIN A PANDEMIC THAT WAS CONSISTENTLY CREATING NEW CHALLENGES. OUR PRIORITY WAS CREATING A SAFE ENVIRONMENT FOR OUR CAREGIVERS, OUR PATIENTS, AND OUR COMMUNITY IN RESPONSE TO THE PANDEMIC. UNION HOSPITAL ROSE TO THAT CHALLENGE AND WILL CONTINUE TO PRIORITIZE ADDRESSING THE PANDEMIC, BUT WE ARE EAGER TO GET BACK INTO OUR COMMUNITIES AND LEARN FROM OUR NEIGHBORS AS WE UNDERTAKE THE 2022 CHNA. NEXT YEAR, WE LOOK FORWARD TO REPORTING ON WHAT WE LEARNED AND THE INITIATIVES WE WILL UNDERTAKE TO ADDRESS OUR NEIGHBORS' NEEDS.

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART VI, LINE 6 (AFFILIATED HEALTHCARE SYSTEM INFORMATION)

UNION HOSPITAL OF CECIL COUNTY, INC. IS PART OF AN AFFILIATED HEALTH CARE SYSTEM IN WHICH AFFINITY HEALTH ALLIANCE, INC. (AHA) IS THE PARENT ENTITY.

AHA'S PURPOSE IS TO SUPPORT THE UNION HOSPITAL OF CECIL COUNTY IN PROVIDING HEALTH CARE AND HEALTH CARE RELATED SERVICES THROUGH THE EFFECTIVE MANAGEMENT OF ALL AFFILIATED CORPORATIONS. SPECIFICALLY, THIS INVOLVES COORDINATING SYSTEM WIDE POLICIES, FUNDRAISING AND STRATEGIC PLANNING PROGRAMS TO PROVIDE HEALTH CARE SERVICES IN RESPONSE TO THE MEDICAL, HUMAN AND RELATED SERVICE NEEDS OF THE COMMUNITY.

OTHER TAX-EXEMPT ORGANIZATIONS IN THE GROUP INCLUDE THE UNION HOSPITAL OF CECIL COUNTY FOUNDATION, INC., UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC., AND UNION HOSPITAL OF CECIL COUNTY ONCOLOGY, INC.

THE FOUNDATION CONDUCTS AND SUPERVISES FUNDRAISING ACTIVITIES ON BEHALF

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

OF ITS TAX-EXEMPT AFFILIATES. THE FOUNDATION ENGAGES IN CORPORATE FUNDRAISING, CAPITAL CAMPAIGNS, SPECIAL EVENTS, ACTIVITIES, AND A MULTI-FACETED COMMUNICATION PROGRAM THAT APPEALS TO PRIVATE AND CORPORATE CONTRIBUTORS.

UNION HOSPITAL OF CECIL COUNTY HEALTH SERVICES, INC.'S MISSION IS TO OWN, MANAGE AND MAINTAIN PROPERTIES FOR HEALTH RELATED VENTURES TO SERVICE CECIL COUNTY AND THE SURROUNDING AREAS. THE ACTIVITIES OF THIS CORPORATION COMPLEMENT AND AUGMENT THE HEALTH CARE ACTIVITIES OF THE HOSPITAL.

UNION HOSPITAL OF CECIL COUNTY ONCOLOGY, INC'S (THE "CORPORATION") DUTY AND MISSION IS TO PROVIDE HIGH QUALITY, ADVANCED RADIATION ONCOLOGY SERVICES TO THE CECIL COUNTY AREA IN ORDER TO FOSTER THE BEST CANCER TREATMENT PROCESS CLOSE TO HOME. CANCER-RELATED DEATHS ARE AMONG THE HIGHEST CAUSES OF MORTALITY IN CECIL COUNTY, SO IT IS THE CORPORATION'S MISSION TO BRING SOME OF THE MOST ADVANCED RADIATION THERAPIES TO CECIL COUNTY TO PROVIDE THE MOST COMPREHENSIVE CANCER CARE POSSIBLE TO THE

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PEOPLE LIVING WITH CANCER HERE AND IN NEIGHBORING COMMUNITIES. BY OFFERING THESE ADVANCED CANCER TREATMENT OPTIONS, THE CORPORATION FURTHERS ITS CHARITABLE PURPOSE OF PROVIDING MEDICAL SERVICES TO PROMOTE THE HEALTH AND WELFARE OF THE RESIDENTS OF CECIL COUNTY AND NEIGHBORING COMMUNITIES.

UNION HOSPITAL OF CECIL COUNTY VENTURES, INC. IS A FOR-PROFIT STOCK CORPORATION. ITS PURPOSE IS TO ENGAGE IN ANY BUSINESS OR TRANSACTION WHICH WILL BENEFIT THE ACTIVITIES AND GOALS OF ITS AFFILIATES. OPERATIONS CONSIST PRIMARILY OF PROVIDING MANAGEMENT SUPPORT SERVICES FOR PHYSICIAN PRACTICES AND PROVIDING IMAGING SERVICES TO PHYSICIANS AND HEALTH CENTERS THROUGH ITS WHOLLY OWNED SUBSIDIARIES, TRIANGLE ALLIANCE LLC AND OPEN MRI AND IMAGING CENTER OF ELKTON LLC.

ON JANUARY 1, 2020, AHA BECAME A MEMBER OF CHRISTIANA CARE HEALTH SYSTEM. CHRISTIANA CARE IS A MAJOR TEACHING HEALTH SYSTEM WITH MORE THAN 1,600 MEDICAL-STAFF MEMBERS AND 260 MEDICAL-DENTAL RESIDENTS AND FELLOWS AND INCLUDES A NUMBER OF ENTITIES INCLUDING CHRISTIANA CARE HEALTH SERVICES,

Part VI Supplemental Information

Provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

INC.

PART VI, LINE 7 (STATES FILING OF COMMUNITY BENEFIT REPORT)

LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT: MD

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2020

**Open to Public
Inspection**

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|--|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

3 Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- | | |
|---|---|
| <input checked="" type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input checked="" type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
 - b** Participate in or receive payment from a supplemental nonqualified retirement plan?
 - c** Participate in or receive payment from an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
 - b** Any related organization?
- If "Yes" on line 5a or 5b, describe in Part III.

6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

- a** The organization?
 - b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III.

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1a		
1b		
2		
3		
4a	X	
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7	X	
8		X
9		

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule J (Form 990) 2020

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.

Note: The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990	
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation					
1	AMY MARSTON CAMPUS OPERATIONS OFFICER	(i)	0.	0.	0.	0.	0.	0.	
		(ii)	156,894.	19,801.	16,742.	5,958.	20,782.	220,177.	0.
2	CRAIG M. BABBITT, ESQ. FMR IN-HOUSE LEGAL COUNSEL	(i)	0.	0.	176,256.	0.	0.	176,256.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
3	DERON BROWN EXEC DIRECTOR OF FINANCE	(i)	148,018.	29,740.	578.	1,529.	843.	180,708.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
4	RYAN T. GERACIMOS, MD CHIEF MEDICAL OFFICER	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	368,659.	73,732.	18,973.	4,275.	2,094.	467,733.	0.
5	EUGENIA M. GRAY, MD PHYSICIAN	(i)	396,622.	11,250.	2,661.	4,275.	15,488.	430,296.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
6	FAHD RAHMAN, MD PHYSICIAN	(i)	381,770.	85,446.	119,325.	4,275.	27,280.	618,096.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
7	JAMES G. RAAB SENIOR VP/CFO (THRU 10/09/20)	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	215,853.	55,095.	57,188.	3,274.	18,012.	349,422.	0.
8	JOAN PIRRUNG VP OF NURSING	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	147,853.	19,199.	979.	33,077.	20,187.	221,295.	0.
9	JOHN M. HEBEKA, MD PHYSICIAN	(i)	357,707.	22,090.	43,014.	4,275.	2,759.	429,845.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
10	JOSE MA, MD DIRECTOR	(i)	214,009.	42,314.	23,610.	3,129.	26,769.	309,831.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
11	JUSTIN SAUSVILLE, MD DIRECTOR, PHYSICIAN	(i)	432,366.	18,750.	218,636.	4,275.	27,411.	701,438.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
12	KENNETH SILVERSTEIN, MD DIRECTOR (AS OF 01/01/21)	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	727,596.	175,162.	790.	88,590.	19,869.	1,012,007.	0.
13	MICHELLE TWUM-DANSO DIRECTOR HR SERVICES	(i)	176,161.	35,352.	9,188.	2,101.	1,679.	224,481.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
14	NAVEED HASAN, MD PHYSICIAN	(i)	364,510.	27,500.	152,443.	4,275.	10,883.	559,611.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.
15	RICHARD C. SZUMEL, MD PRESIDENT & CEO (THRU 12/20)	(i)	0.	0.	0.	0.	0.	0.	0.
		(ii)	464,350.	93,188.	21,670.	43,520.	8,452.	631,180.	0.
16	ROGER D. WU, MD PHYSICIAN	(i)	470,883.	71,574.	73,650.	4,275.	23,117.	643,499.	0.
		(ii)	0.	0.	0.	0.	0.	0.	0.

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that aren't listed on Form 990, Part VII.

Note: The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
JENNIFER L. SCHWARTZ, E 1 SECRETRY, EX OFF.(AS OF 01//21)	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	476,416.	114,452.	0.	62,881.	19,869.	673,618.	0.
2	(i)							
	(ii)							
3	(i)							
	(ii)							
4	(i)							
	(ii)							
5	(i)							
	(ii)							
6	(i)							
	(ii)							
7	(i)							
	(ii)							
8	(i)							
	(ii)							
9	(i)							
	(ii)							
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

FORM 990, SCHEDULE J, PART I, LINE 4A

DETAIL OF SEVERANCE PAYMENTS

THE FOLLOWING INDIVIDUALS RECEIVED SEVERANCE PAYMENTS DURING THE CALENDAR

YEAR 2020:

- CRAIG M. BABBITT, ESQ. \$176,256

FORM 990, SCHEDULE J, PART I, LINE 4B

SUPPLEMENTAL NONQUALIFIED PLAN PARTICIPATION

DR. RICHARD C. SZUMEL (PRESIDENT & CEO) PARTICIPATES IN A SUPPLEMENTAL,

NON-QUALIFIED RETIREMENT PLAN UNDER SECTION 457(F) OF THE INTERNAL

REVENUE CODE WITH CONTRIBUTION AMOUNT OF \$39,245 AND RECEIVED A

DISTRIBUTION AMOUNT OF \$219,628 DURING THE CALENDAR YEAR 2020.

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

FORM 990, SCHEDULE J, PART I, LINE 7

PROVISION OF NON-FIXED PAYMENTS

A PORTION OF THE BONUSES AND MERIT INCREASE ARE TIED TO THE ORGANIZATIONAL GOALS, SUCH AS PATIENT SATISFACTION, QUALITY, EMPLOYEE TURNOVER, ETC.

A PORTION OF THE BONUSES AND MERIT INCREASE ARE ALSO TIED TO EXPENSES PER EQUIVALENT INPATIENT DAYS OF UNION HOSPITAL OF CECIL COUNTY.

**SCHEDULE K
(Form 990)**

Supplemental Information on Tax-Exempt Bonds

OMB No. 1545-0047

2020

**Open to Public
Inspection**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

▶ **Attach to Form 990.**

▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Department of the Treasury
Internal Revenue Service

Name of the organization
UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number
52-0607945

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A TOWN OF ELKTON - SERIES 2012A	52-6000790		05/18/2012	10,000,000.	REFUND PORTION OF SERIES 2009 BOND		X		X		X
B TOWN OF ELKTON - SERIES 2012B1/B2	52-6000790		05/18/2012	8,662,336.	REFUND SERIES 2009 & 2000 BONDS		X		X		X
C TOWN OF ELKTON - SERIES 2012C	52-6000790		05/18/2012	9,000,000.	REFUND ESCROW TO REPAY 2002 BOND		X		X		X
D MD HEALTH & HIGHER EDUCATION FACILITIES AUTHORITY	52-0936091		07/18/2012	9,924,000.	REFUND PORTION OF SERIES 2002 BOND		X		X		X

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired	2,975,773.		4,594,977.				8,795,875.	
2 Amount of bonds legally defeased								
3 Total proceeds of issue	10,000,000.		8,662,336.		9,000,000.		9,924,000.	
4 Gross proceeds in reserve funds								
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds								
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds								
11 Other spent proceeds	10,000,000.		8,662,336.		9,000,000.		9,924,000.	
12 Other unspent proceeds								
13 Year of substantial completion	2012		2012		2012		2012	
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X		X		X		X	
15 Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X		X		X		X
16 Has the final allocation of proceeds been made?	X		X		X		X	
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule K (Form 990) 2020

**SCHEDULE K
(Form 990)**

Supplemental Information on Tax-Exempt Bonds

OMB No. 1545-0047

2020

**Open to Public
Inspection**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

▶ **Attach to Form 990.**

▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Department of the Treasury
Internal Revenue Service

Name of the organization
UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number
52-0607945

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A MD HEALTH & HIGHER EDUCATION FACILITIES AUTHORITY	52-0936091		07/18/2012	4,007,000.	FINANCE ACQUISITION OF EQUIPMENT		X		X		X
B MD HEALTH & HIGHER EDUCATION FACILITIES AUTHORITY	52-0936091		12/01/2014	30,778,000.	REFINANCE THE 2005 BOND	X			X		X
C											
D											

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired	3,506,463.		900,000.					
2 Amount of bonds legally defeased								
3 Total proceeds of issue	4,007,000.		30,778,000.					
4 Gross proceeds in reserve funds								
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds								
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds								
11 Other spent proceeds	4,007,000.		30,778,000.					
12 Other unspent proceeds								
13 Year of substantial completion	2012		2014					
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X		X					
15 Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)?		X		X				
16 Has the final allocation of proceeds been made?	X		X					
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule K (Form 990) 2020

Part III Private Business Use TAX-EXEMPT BONDS

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		X
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X		X		X		X
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X		X		X	
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X		X	
c Are there any research agreements that may result in private business use of bond-financed property?		X		X		X		X
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶								
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6 Total of lines 4 and 5								
7 Does the bond issue meet the private security or payment test?		X		X		X		X
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		X
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X		X		X	

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X		X		X
b Exception to rebate?	X		X		X		X	
c No rebate due?		X		X		X		X
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X		X		X		X

Part III Private Business Use TAX-EXEMPT BONDS 2

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X				
2 Are there any lease arrangements that may result in private business use of bond-financed property?		X		X				
3a Are there any management or service contracts that may result in private business use of bond-financed property?	X		X					
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X					
c Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶								
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6 Total of lines 4 and 5								
7 Does the bond issue meet the private security or payment test?		X		X				
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X					

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X				
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X				
b Exception to rebate?	X		X					
c No rebate due?		X		X				
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X		X				

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions) *(Continued)*

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

OMB No. 1545-0047

Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.

2020

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▶ Attach to Form 990 or 990-EZ.

▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

FORM 990, PART VI, SECTION A, LINE 6

DETAIL OF MEMBERS AND STOCKHOLDERS

CHRISTIANA CARE HEALTH SERVICES, INC. IS THE SOLE MEMBER OF AFFINITY
HEALTH ALLIANCE ("AFFINITY"), BOTH TAX-EXEMPT ORGANIZATIONS. AFFINITY IS
THE SOLE MEMBER OF THE UNION HOSPITAL OF CECIL COUNTY, INC.

FORM 990, PART VI, SECTION A, LINE 7A

GOVERNING BODY AND MANAGEMENT

THE BYLAWS OF THE HOSPITAL PROVIDE THAT ITS DIRECTORS ARE APPOINTED BY
ITS SOLE MEMBER, AFFINITY.

FORM 990, PART VI, SECTION A, LINE 7B

GOVERNING BODY AND MANAGEMENT

THE BYLAWS OF THE HOSPITAL PROVIDE THAT ITS SOLE MEMBER (AFFINITY) MAY
AMEND ITS BYLAWS.

FORM 990, PART VI, SECTION B, LINE 11B

FORM 990 REVIEW PROCESS

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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INFORMATION RELATED TO THE UNION HOSPITAL OF CECIL COUNTY, INC. FORM 990 IS GATHERED BY FINANCE STAFF AND PROVIDED TO PRICEWATERHOUSECOOPERS LLP FOR REVIEW. THE FINAL 2020 FORM 990 FOR THE FISCAL YEAR ENDING JUNE 30, 2021 WAS REVIEWED AND APPROVED BY VARIOUS SENIOR MANAGEMENT OFFICIALS. THE ORGANIZATION'S GOVERNING BOARD WAS ALSO PROVIDED ACCESS TO THE APPROVED 2020 FORM 990 VIA ITS BOARD OF DIRECTORS PORTAL.

FORM 990, PART VI, SECTION B, LINE 12C
CONFLICT OF INTEREST POLICY

BOARD MEMBERS AND OFFICERS ARE REQUIRED TO ANNUALLY DISCLOSE ANY POTENTIAL CONFLICT OF INTEREST. THE ORGANIZATION'S CEO REVIEWS THE SIGNED ANNUAL DISCLOSURES. THE CORPORATE COMPLIANCE OFFICER IS MADE AWARE OF ANY DISCLOSED CONFLICT, INVESTIGATES THE CONFLICT, AND REPORTS BACK TO THE BOARD OF DIRECTORS. THE BOARD CONSIDERS THE FACTS AND MAKES AN APPROPRIATE FINDING. ANY BOARD MEMBER WITH A CONFLICT MUST ABSTAIN FROM BOARD DELIBERATIONS AND VOTING ON THE MATTER.

ALL VICE PRESIDENTS ANNUALLY RECEIVE A LIST OF THE INDIVIDUALS UNDER THEIR SUPERVISION WHO MAY HAVE A POTENTIAL CONFLICT OF INTEREST. THE LIST IS COMPRISED OF ALL MANAGERS, CERTAIN PROFESSIONAL STAFF WHO MAY HAVE RESPONSIBILITY NEGOTIATING WITH VENDORS, AND ANY OTHER PERSONS THAT HOSPITAL EXECUTIVES DEEM APPROPRIATE. EACH VICE PRESIDENT REVIEWS THE CONFLICT OF INTEREST POLICY WITH THEIR DESIGNATED EMPLOYEES, AND EACH

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

EMPLOYEE IS REQUIRED TO SIGN A FORM STIPULATING WHETHER OR NOT THEY HAVE A CONFLICT. THE FORMS ARE REVIEWED BY THE VICE PRESIDENT OF HUMAN RESOURCES. IF A CONFLICT IS NOTED, IT IS BROUGHT TO THE ATTENTION OF THE APPROPRIATE VICE PRESIDENT AND THE CEO TO DETERMINE WHETHER OPERATIONAL CHANGES NEED TO OCCUR BECAUSE OF THE POTENTIAL CONFLICT.

FORM 990, PART VI, SECTION B, LINE 15
COMPENSATION REVIEW AND APPROVAL PROCESS

THE COMPENSATION COMMITTEE OF THE ORGANIZATION'S BOARD OF DIRECTORS IS RESPONSIBLE FOR SETTING THE OVERALL COMPENSATION PHILOSOPHY OF THE ORGANIZATION, AS WELL AS SETTING, MONITORING AND REVIEWING THE COMPENSATION PACKAGE OF THE ORGANIZATION'S CEO AND OTHER MEMBERS OF THE EXECUTIVE MANAGEMENT TEAM. THE COMMITTEE USES RELEVANT MARKET INFORMATION, INCLUDING THE USE OF AN INDEPENDENT COMPENSATION CONSULTANT AND COMPENSATION OR SURVEYS, TO SET COMPENSATION. DURING FISCAL YEAR 2020, AN INDEPENDENT COMPENSATION CONSULTANT PROVIDED THE FOLLOWING SERVICES: EXECUTIVE COMPENSATION AND PERFORMANCE EVALUATION.

COMPENSATION REVIEW AND APPROVAL IS DOCUMENTED VIA BOARD MINUTES.

FORM 990, PART VI, SECTION C, LINE 19
GOVERNANCE, MANAGEMENT & DISCLOSURE

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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THE ORGANIZATION MAKES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS AVAILABLE TO THE PUBLIC UPON REQUEST.

FORM 990, PART XI, LINE 9

DETAIL OF OTHER CHANGES IN NET ASSETS

CHANGE IN NET ASSETS OF FOUNDATION	\$ 1,018,482
BAD DEBT EXPENSE	207,277
OTHER CHANGES	10,759
TOTAL	\$ 1,236,518

ATTACHMENT 1

FORM 990, PART III - PROGRAM SERVICE, LINE 4A

UNION HOSPITAL OF CECIL COUNTY'S MISSION IS TO PROVIDE QUALITY HEALTH CARE SERVICES TO THE RESIDENTS OF CECIL COUNTY, MARYLAND AND NEIGHBORING COMMUNITIES. SERVICES ARE PROVIDED WITH MODERN TECHNOLOGY AND COMPASSIONATE CARE FROM HEALTH CARE PROFESSIONALS. SERVICES ARE PROVIDED REGARDLESS OF RACE, GENDER, ETHNICITY, AGE, DISABILITY, RELIGION, OR ABILITY TO PAY. ALTHOUGH REIMBURSEMENT FOR SERVICES RENDERED IS VITALLY IMPORTANT TO THE OPERATION, STABILITY, AND VIABILITY OF UNION HOSPITAL OF CECIL COUNTY, IT IS RECOGNIZED THAT NOT ALL MEMBERS OF THE COMMUNITY ARE IN THE FINANCIAL POSITION TO PURCHASE HEALTH CARE SERVICES. FOR ELIGIBLE INDIVIDUALS, UNION HOSPITAL OF CECIL COUNTY OFFERS FREE AND/OR SUBSIDIZED CARE, AS WELL AS ACCESS TO COMMUNITY FINANCIAL

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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ATTACHMENT 1 (CONT'D)

ASSISTANCE.

DURING THE YEAR, UNION HOSPITAL OF CECIL COUNTY PROVIDED \$11,792,462 IN UNCOMPENSATED CARE (CHARITY CARE).

IN ADDITION, COMMUNITY BENEFIT ACTIVITIES ARE PROVIDED TO SERVE VULNERABLE POPULATIONS (I.E. MEDICALLY UNDERSERVED, WORKING POOR, HOMELESS). ACTIVITIES ARE CREATED BASED ON COMMUNITY NEED AND ARE PROVIDED IN AN EFFORT TO IMPROVE THE HEALTH OF THE COMMUNITY.

COMMUNITY BENEFITS INCLUDE:

- A) COMMUNITY SUPPORT GROUPS FOR CANCER, DIABETES, STROKE, ALZHEIMER'S, AND BREASTFEEDING;
- B) HEALTH EDUCATION FOR DIABETES AND NUTRITION, CANCER PREVENTION, STROKE RISK, AND HOW TO CARE FOR SUBSTANCE-EFFECTED NEWBORNS;
- C) FREE SCREENINGS IN THE COMMUNITY FOR PROSTATE CANCER, HEAD AND NECK CANCER, SKIN CANCER, AND DIABETES (EYES AND FEET);
- D) PROVIDING MEETING FACILITIES FOR LOCAL NONPROFITS AND AGENCIES
- E) ENHANCING FOOD SECURITY WITH MEALS ON WHEELS AND FOOD DONATIONS TO HOMELESS SERVING PROVIDERS IN THE COMMUNITY;
- F) HOSPITAL STAFF PARTICIPATION ON COMMUNITY BOARDS AND COALITIONS, LIKE THE DENTAL HEALTH ADVISORY BOARD, UNITED WAY, VOICES OF HOPE, CECIL COUNTY DRUG-FREE COMMUNITIES COALITION, CORE SERVICE AGENCY MENTAL HEALTH ADVISORY BOARD, DEPARTMENT OF SOCIAL SERVICES BOARD, AND CECIL COUNTY COMMUNITY HEALTH ADVISORY

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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ATTACHMENT 1 (CONT'D)

COALITION.

UNION HOSPITAL OF CECIL COUNTY SERVICED 4,506 DISCHARGES,
PROVIDING 20,868 PATIENT DAYS TO INPATIENTS IN FISCAL YEAR 2021 OF
WHICH:

- 1) PATIENTS COVERED UNDER THE MEDICARE PROGRAM WERE 2,028
DISCHARGES AND 10,451 PATIENT DAYS;
- 2) PATIENTS COVERED UNDER THE MEDICAID PROGRAM WERE 112 DISCHARGES
AND 527 PATIENT DAYS;
- 3) PATIENTS COVERED UNDER THE MEDICAID HMO PROGRAM WERE 1,456
DISCHARGES AND 5,054 PATIENT DAYS;
- 4) PATIENTS COVERED UNDER THE MEDICARE HMO PROGRAM WERE 209
DISCHARGES AND 1,219 PATIENT DAYS.

ATTACHMENT 2990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
UNION RADIOLOGISTS, LLC 106 BOW STREET RADIOLOGY OFFICE ELKTON, MD 21921	RADIOLOGY SERVICES	3,456,500.
USACS INTEGRATED ACUTE CARE SRVCS OF MD 4535 DRESSLER RD NW CANTON, OH 44718	ACUTE CARE SERVICES	2,426,516.
CHG COMPANIES, INC. PO BOX 972651 DALLAS, TX 75397	PROF. STAFFING SRVCS	2,301,704.
GENERAL HEALTHCARE RESOURCES, LLC 2250 HICKORY RD	PROF. STAFFING SRVCS	1,570,542.

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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ATTACHMENT 2 (CONT'D)

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
PLYMOUTH MEETING, PA 19460		
LAB CORP OF AMERICA HOLDINGS, INC. PO BOX 1290 BURLINGTON, NC 27216	PURCHASED SERVICES	950,380.

ATTACHMENT 3

FORM 990, PART IX - OTHER FEES

<u>DESCRIPTION</u>	(A) <u>TOTAL FEES</u>	(B) <u>PROGRAM SERVICE EXP.</u>	(C) <u>MANAGEMENT AND GENERAL</u>	(D) <u>FUNDRAISING EXPENSES</u>
CONTRACTED SERVICES	8,822,374.	3,373,330.	5,449,044.	0.
PHYSICIAN SERVICES	12,140,813.	12,082,963.	57,850.	0.
PURCHASED SERVICES & FEES	3,201,181.	2,759,563.	441,618.	0.
AGENCY EMPLOYEES	2,944,618.	2,202,696.	741,922.	0.
TRANSCRIPTION SERVICES	197,736.	49,656.	148,080.	0.
CLEANING SERVICES	157,403.	123,403.	34,000.	0.
BILLING & COLLECTIONS SERVICES	93,130.	93,130.	0.	0.
ADMINISTRATIVE SERVICES	418.	418.	0.	0.
TOTALS	<u>27,557,673.</u>	<u>20,685,159.</u>	<u>6,872,514.</u>	<u>0.</u>

ATTACHMENT 4

Name of the organization UNION HOSPITAL OF CECIL COUNTY, INC.	Employer identification number 52-0607945
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ATTACHMENT 4 (CONT'D)

FORM 990, PART X - INVESTMENTS - PUBLICLY TRADED SECURITIES

<u>DESCRIPTION</u>	<u>BEGINNING BOOK VALUE</u>	<u>ENDING BOOK VALUE</u>	<u>COST OR FMV</u>
INVESTMENTS	30,670,970.	43,359,783.	FMV
TOTALS	<u>30,670,970.</u>	<u>43,359,783.</u>	

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2020

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▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**

▶ **Attach to Form 990.**

▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Department of the Treasury
Internal Revenue Service

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

Part II Identification of Related Tax-Exempt Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) UNION HOSPITAL OF CECIL COUNTY FDN, INC. 52-1794552 106 BOW STREET ELKTON, MD 21921	FUNDRAISING	MD	501(C)(3)	7	AFFINITY		X
(2) UNION HOSPITAL OF CECIL COUNTY HLTH SVCS 52-1794553 106 BOW STREET ELKTON, MD 21921	PROPERTY MGMT	MD	501(C)(3)	10	AFFINITY		X
(3) AFFINITY HEALTH ALLIANCE, INC. 52-1794697 106 BOW STREET ELKTON, MD 21921	MANAGEMENT	MD	501(C)(3)	12B, II	CCH SERVICES		X
(4) UNION HOSPITAL OF CECIL COUNTY ONCOLOGY 81-2662359 106 BOW STREET ELKTON, MD 21921	HEALTHCARE	MD	501(C)(3)	3	AFFINITY		X
(5) CHRISTIANA CARE HEALTH SYSTEM, INC. 52-1479538 501 WEST 14TH STREET WILMINGTON, DE 19801	FUNDRAISING	DE	501(C)(3)	7	N/A		X
(6) CHRISTIANA CARE HLTH INITIATIVES, INC. 51-0295186 200 HYGEIA DRIVE, SUITE 2300 NEWARK, DE 19713	OUTPATIENT SV	DE	501(C)(3)	10	CCH SYSTEM		X
(7) CHRISTIANA CARE HOME HEALTH & COM SRVCS 51-0064334 1 READS WAY NEW CASTLE, DE 19720	HOME HLTHCARE	DE	501(C)(3)	7	CCH SYSTEM		X

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2020

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2020

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Inspection**

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**

▶ **Attach to Form 990.**

▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Name of the organization

UNION HOSPITAL OF CECIL COUNTY, INC.

Employer identification number

52-0607945

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

Part II Identification of Related Tax-Exempt Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) CHRISTIANA CARE HEALTH SERVICES, INC. 51-0103684 P.O. BOX 2653 WILMINGTON, DE 19805	HOSPITAL	DE	501(C)(3)	3	CCH SYSTEM		X
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule R (Form 990) 2020

Part III Identification of Related Organizations Taxable as a Partnership. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) CHRISTIANACARE GOHEALTH URGENT 5555 GLENRIDGE CONNECTOR, STE	URGENT CARE SRVCS	DE	CCH SERVICES								X	
(2) CHRISTIANACARE VALUE HEALTH JV 11221 ROE AVE LEAWOOD, KS 6621	AMBULATORY SRVCS	DE	CCH SERVICES								X	
(3) CLINERGY, LLC 85-2698063 4755 OGLETOWN STANTON RD NEWAR	GROUP PURCHASING	DE	CCH SERVICES								X	
(4) LEEWARD HEALTH, LLC 4000 NEXUS DRIVE, STE C3-300 W	MED ADV RISK SHAR	DE	CCH SYSTEM								X	
(5)												
(6)												
(7)												

Part IV Identification of Related Organizations Taxable as a Corporation or Trust. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) UNION HOSPITAL OF CECIL COUNTY VENTURES 52-1793691 106 BOW STREET ELKTON, MD 21921	MEDICAL SERVICES	MD	AFFINITY	C CORP					X
(2) THE DE CTR FOR MAT FETAL MED OF CC, INC. 20-5891272 4000 NEXUS DR. STE NW3-100 WILMINGTON, DE 19803	HEALTHCARE	DE	CCH SERVICES	C CORP					X
(3) CHRISTIANA CARE HEALTH PLANS 51-0352728 4000 NEXUS DR. STE NW3-100 WILMINGTON, DE 19803	INSURANCE	DE	CCH SYSTEM	C CORP					X
(4) CHRISTIANA CARE DEFERRED COMP PLAN 81-6359549 4755 OGLETOWN STANTON RD NEWARK, DE 19718	DEF COMP PLAN	DE	CCH SERVICES	TRUST					X
(5) CHRISTIANA CARE EXEC DEFERRED COMP PLAN 35-7048822 4755 OGLETOWN STANTON RD NEWARK, DE 19718	DEF COMP PLAN	DE	CCH SERVICES	TRUST					X
(6) CARE ASSOCIATES DEFERRED COMP PLAN 35-7048714 4755 OGLETOWN STANTON RD NEWARK, DE 19718	DEF COMP PLAN	DE	CCH SERVICES	TRUST					X
(7) CHRISTIANA CARE INSURANCE CO, LTD 98-1489490 P.O. BOX 1159, 878 W. BAY RD GRAND CAYMAN, CJ KY1-1102	SELF-INSURANCE	CJ	CCH SERVICES	C CORP					X

Part III Identification of Related Organizations Taxable as a Partnership. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

Part IV Identification of Related Organizations Taxable as a Corporation or Trust. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) CHRISTIANA CARE STRATEGIC INVESTMENTS 85-3348300 4000 NEXUS DR. STE NW3-100 WILMINGTON, DE 19803	STRATEGY	DE	CCH SYSTEM	C CORP					X
(2) CENTER FOR VIRTUAL HEALTH, LLC 86-2155365 4000 NEXUS DR., STE C3-300 WILMINGTON, DE 19803	MNGMT & SUPPORT	DE	CCH SERVICES	C CORP					X
(3) CENTER FOR VIRTUAL HEALTH PRACTICE PA 86-2158927 4000 NEXUS DR., STE C3-300 WILMINGTON, DE 19803	VIRTUAL PRIM CARE	DE	CNTR VIRTUAL	C CORP					X
(4)									
(5)									
(6)									
(7)									

Part V Transactions With Related Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)	X	
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)		X
e Loans or loan guarantees by related organization(s)		X
f Dividends from related organization(s)		X
g Sale of assets to related organization(s)		X
h Purchase of assets from related organization(s)		X
i Exchange of assets with related organization(s)		X
j Lease of facilities, equipment, or other assets to related organization(s)	X	
k Lease of facilities, equipment, or other assets from related organization(s)		X
l Performance of services or membership or fundraising solicitations for related organization(s)		X
m Performance of services or membership or fundraising solicitations by related organization(s)		X
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	X	
o Sharing of paid employees with related organization(s)	X	
p Reimbursement paid to related organization(s) for expenses	X	
q Reimbursement paid by related organization(s) for expenses	X	
r Other transfer of cash or property to related organization(s)	X	
s Other transfer of cash or property from related organization(s)	X	

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

	(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

Part VI **Unrelated Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512 - 514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part VII **Supplemental Information**

Provide additional information for responses to questions on Schedule R. See instructions.

RENT AND ROYALTY INCOME

Taxpayer's Name UNION HOSPITAL OF CECIL COUNTY, INC.	Identifying Number 52-0607945
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DESCRIPTION OF PROPERTY
 INVESTMENT ACTIVITIES

Yes	No	Did you actively participate in the operation of the activity during the tax year?
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TYPE OF PROPERTY:		
OTHER INCOME:		
TOTAL GROSS INCOME		
OTHER EXPENSES:		
DEPRECIATION (SHOWN BELOW)		6.
LESS: Beneficiary's Portion		
AMORTIZATION		
LESS: Beneficiary's Portion		
DEPLETION		
LESS: Beneficiary's Portion		
TOTAL EXPENSES		6.
TOTAL RENT OR ROYALTY INCOME (LOSS)		-6.

Less Amount to

Rent or Royalty	
Depreciation	
Depletion	
Investment Interest Expense	
Other Expenses	
Net Income (Loss) to Others	
Net Rent or Royalty Income (Loss)	-6.

Deductible Rental Loss (if Applicable)

SCHEDULE FOR DEPRECIATION CLAIMED

(a) Description of property	(b) Cost or unadjusted basis	(c) Date acquired	(d) ACRS des.	(e) Bus. %	(f) Basis for depreciation	(g) Depreciation in prior years	(h) Method	(i) Life or rate	(j) Depreciation for this year
SEE ATTACHMENT									
Totals									

RENT AND ROYALTY SUMMARY

<u>PROPERTY</u>	<u>TOTAL INCOME</u>	<u>DEPLETION/ DEPRECIATION</u>	<u>OTHER EXPENSES</u>	<u>ALLOWABLE NET INCOME</u>
INVESTMENT ACTIVITIE		6.		-6.
LABORATORY SERVICES		23,599.		-23,599.
TOTALS		<u>23,605.</u>		<u>-23,605.</u>